BROWARD HEALTH

CONFIDENTIALITY AND SECURITY AGREEMENT

I understand that Broward Health has a legal and ethical responsibility to safeguard the privacy of all patients. Additionally, Broward Health must ensure the confidentiality of its human resources, payroll, fiscal, research, internal reporting, strategic planning, communications, computer systems, and management information (collectively with patient identifiable health information, "Confidential Information"). As an employee, student, volunteer, medical staff member, contractor, or other individual who performs services on behalf of Broward Health or one of its entities, I understand that I must sign and comply with this Agreement to obtain authorization for access to Confidential Information. By signing below, I agree to the following conditions:

The following statements apply to all individuals having authorized access to Broward Health systems.

1. My username and password are the equivalent of my signature.
2. I am the only person authorized to use my username and password. I will not disclose my password to anyone or allow others to use my username.
3. I will choose a password which I can remember and that is difficult for others to guess.
4. I will not write my password where another individual may find it.
5. I will log out or secure my workstation whenever I leave the workstation unattended.
6. I will not use a workstation which has been logged onto by another user unless I log them out.
7. I will not attempt to learn another person's username/password and I will not attempt to access information using a username other than my own.
8. All information gained by my password will be treated as confidential and never be released to any person unless I have been authorized to release that information.
9. I understand that I will be held responsible for all actions which I allow to occur under my username or which occur due to my negligence.
10. I will only access and use Confidential Information when it is necessary to perform my job responsibilities in accordance with Broward Health's Privacy and Security Policies.
11. I understand that Broward Health maintains audit trails of access to information and system activity and that the audit trail may be reviewed at any time.
12. I understand the policy governing the use of the Internet and will comply with this policy at all times.
13. I will use all information gained through the computer system for the benefit of Broward Health and its patients.
14. I understand the need to protect Broward Health information both during my relationship with Broward Health and after termination of my relationship. I will protect the confidentiality of all information that I use, originate, discover, or develop in the performance of my duties at Broward Health.
15. I will not electronically copy or transmit Confidential Information not directly related to my authorized duties without specific written authorization from an authorized source.
16. I will participate in all future compliance, privacy, and security training requirements required of my position.
17. I will report any and all suspected privacy and security breaches in accordance with Broward Health's HIPAA privacy and security breach reporting process.
18. I understand that violation of this agreement may result in corrective action, up to and including immediate termination and/or legal prosecution and notification of law enforcement officials and/or state accreditation and licensure boards.

Additionally, the following statements apply to all physicians using Broward Health systems containing patient identifiable health information.

19. I understand that by accessing a patient's record, I am affirmatively representing to Broward Health at the time of each access that I have a requisite business need to know and that Broward Health may rely on that representation in granting such access to me.
20. I will ensure that only appropriate personnel in my office will access Broward Health systems and Confidential Information as authorized by me and in accordance with Broward Health policies and procedures. I will ensure that such personnel receive annual training on issues related to patient confidentiality and access.
21. I will accept full responsibility for the actions of my employees who are granted access to Broward health systems and Confidential Information.

_____ _____

Name Signature

Date: ____/____/____ Employee/Physician ID # _____ Accounting Unit _____

Region(s): ☐ BHMC / BHCH ☐ BHN ☐ BHIP ☐ BHCS ☐ Other _____

Physician Practice (*specify site*): _____

Relationship to Broward Health: ☐ Employee ☐ Student ☐ Volunteer ☐ Medical Staff ☐ Allied Health Professional

Contractor (*specify employer*): _____

Other (*specify*): _____

NORTH BROWARD HOSPITAL DISTRICT
d/b/a BROWARD HEALTH

OBSERVATIONAL EXPERIENCE APPLICANT CHECKLIST

This form must be completed in its entirety and returned to the Medical Staff Office(s) where you have requested to observe. Observerships may not commence until you have been approved and notified by the Medical Staff Office(s).

Name	
Phone Number	
Email Address	
Date of Birth	
License Number (if applicable)	
Type of License (if applicable)	
Hospital Location Requested	
Area / Department Requested	
Physician Observing	
Physician Specialty	
Dates of Observation	
Reason for Observation	

Visit https://doctor.browardhealth.org for details

Along with this form, you must also provide the following:

- ❑ Copy of your U.S. government-issued photo ID (i.e. driver's license, passport)
- ❑ Copy of your health insurance card
- ❑ Observational Experience Request and Agreement
- ❑ Observational Experience Sponsoring Physician Agreement
- ❑ Observational Experience Acknowledgement
- ❑ Observational Experience Influenza Vaccine Survey
- ❑ Certificates of Completion of all required online orientation modules
- ❑ Copy of negative TB test results or negative chest x-ray
- ❑ Confidentiality and Data Security Agreement
- ❑ Copy of your Covid-19 Vaccine Card

Please refer to https://doctor.browardhealth.org for contact information if you have questions or need assistance

Orientation modules can be found at:
www.browardhealth.org/orientation/orientation-pages/students-interns-and-instructors-orientation

Exhibit B

BROWARD HEALTH

NORTH BROWARD HOSPITAL DISTRICT
d/b/a BROWARD HEALTH

OBSERVATIONAL EXPERIENCE REQUEST AND AGREEMENT

By completing this form, all parties named below hereby request participation in an observational experience within the Broward Health system. All parties have read the Broward Health policy entitled "Observers in Broward Health Hospitals" and agree to abide by said policy at all times during the observational time period to be approved. Any questions or concerns during said time should be brought to the attention of the Medical Staff Office.

Observer:_____
Signature Print Name Date

Sponsoring Physician:_____
Signature Print Name Date

Requested Hospitals:

- ☐ Broward Health Medical Center/Broward Health Children's Hospital
- ☐ Broward Health North
- ☐ Broward Health Imperial Point
- ☐ Broward Health Coral Springs
- ☐ Broward Community Health Services

Dates to Observe:
From __/__/__ to __/__/__
(*Not to exceed four weeks*)

--------- ***FOR HOSPITAL USE*** ---------

Received By Medical Staff Administration:

_____
Signature Print Name Title Date

Approved As Requested?
- ☐ Yes
- ☐ No
- ☐ With Conditions

Conditions:
_____
_____
_____

This form must be approved by at least one medical staff representative and one hospital senior executive (as designated by the Hospital CEO).

Approved By Hospital Senior Executive:

_____
Signature Print Name Title Date

Approved By Medical Staff Representative:

_____
Signature Print Name Title Date

Approval Communicated by Medical Staff Administration to:
- ☐ Observer
- ☐ Sponsoring Physician
- ☐ Hospital Staff
- ☐ Other

Method:_____
Date:_____

Exhibit C

BROWARD HEALTH

NORTH BROWARD HOSPITAL DISTRICT
d/b/a BROWARD HEALTH

OBSERVATIONAL EXPERIENCE SPONSORING PHYSICIAN AGREEMENT

I, _____ ("Sponsoring Physician") am an active member in good standing of the medical staff at (please check your primary facility below):

- ☐ Broward Health Medical Center/Salah Foundation Children's Hospital
- ☐ Broward Health North
- ☐ Broward Health Imperial Point
- ☐ Broward Health Coral Springs
- ☐ Broward Community Health Services

I hereby request authorization to sponsor _____ (the "Observer") for purposes of clinical observation.

The Sponsoring Physician and Observer understand that:

1. The Sponsoring Physician will be solely responsible for providing the Observer with the opportunity to observe clinical practices within the limitations of Sponsoring Physician's specialty and area of clinical expertise.

2. The Observer is allowed to observe only those patients of the Sponsoring Physician and only in the presence of said Sponsoring Physician.

3. The Observer is not permitted to make any comments or recordings in the official medical record of any patient, nor is the Observer to order, in writing or verbally, any treatment, test, procedure, medication, etc., nor to render any diagnostic or clinical opinions.

4. In no case should confidential information be conveyed to individuals outside the organization, including family or associates, or even other facility employees or other health care team members who do not need the information in performing their job duties.

5. Authorization may be withdrawn at any time, without cause. The relevant facility will notify the Sponsoring Physician and the Observer of the same.

The observer's period of observation with the physician will be from _____ to _____

Sponsoring Physician's Signature: _____

Printed Name: _____

Date: _____

Observer's Signature: _____

Printed Name: _____

Date: _____

Exhibit D

NORTH BROWARD HOSPITAL DISTRICT
d/b/a BROWARD HEALTH

OBSERVATIONAL EXPERIENCE ACKNOWLEDGEMENT

For and in consideration of the benefit provided the undersigned below ("Observer") in the form of an observational experience at the North Broward Hospital District d/b/a Broward Health, a special taxing district of the State of Florida ("Broward Health"), does hereby covenant, acknowledge and/or agree to do the following:

1. Limit experience solely to observation at the specific facilities and times approved by Broward Health. Under no circumstances will Observer participate in, provide or make any decisions relating to the evaluation, care or treatment of any Broward Health patient. All decisions relating to the evaluation, care and treatment of each individual patient will be made solely by Broward Health physicians, nurses or other authorized Broward Health personnel. This includes, but is not limited to, Observers not reviewing, writing in charts, or touching patients.

2. Abide by all policies, procedures, rules and regulations of Broward Health.

3. Present and conduct himself/herself in a manner that is professionally and ethically appropriate and that does not interfere with or create any risk of harm to Broward Health, its patients, employees, agents, or any persons on Broward Health premises.

4. Maintain the absolute confidentiality of all information (whether in oral, electronic or paper form) that Observer may have access to during his/her experience at Broward Health.

5. Reimburse and indemnify Broward Health for any damages or other injuries caused by Observer while participating in his/her observational experience at Broward Health.

6. Refrain from representing himself/herself as an agent, representative, or employee of Broward Health at any time. Observers should check in each day at the visitor's desk to obtain a visitor's pass, unless otherwise instructed. Visitor's pass should be prominently displayed at all times. Observers may not wear lab coats, jackets, or carry a stethoscope or any other medical evaluation equipment.

7. Assume all risks of, and be solely responsible for, any injury or illness, including medical care and treatment expenses, while participating in his/her observational experiences at Broward Health.

8. Vacate the premises if Broward Health determines that my observational experience is not in the best interest of its patients or personnel.

9. Assume the risk of possible exposure to hazards that could result in personal injury, illness, or death, among others.

10. I certify that I have received the Broward Health Code of Conduct, understand it represents mandatory policies of the organization, and agree to abide by it.

Dated this_____ day of _____,20_____.

_____
Observer's Signature

Printed Name:_____

Phone Number:_____

_____
Parent's Signature (if observer is under age 18)

Printed Name: _____

Phone Number:_____

Exhibit E

BROWARD HEALTH®

Observational Experience Influenza Vaccine Survey 20__-20__

Applicant Name: _____

1. Did you receive the influenza vaccine during the 20__-20__ Influenza Season (October 1, 20__- March 31, 20__)?

   Yes _____ ***(If yes, continue to Question 2)*** No _____ ***(If no, Skip to Question 5)***

---

2. Month/Year Vaccine received _____
3. Please attach proof of flu vaccine
4. Please sign below

Thank you. This survey is Complete.

---

5. Reason(s) for Declination of Flu Vaccine (for educational purposes)
   a. Medical Contraindication _____ (i.e. Guillain-Barre' Syndrome within 6 weeks after previous influenza vaccination or severe anaphylactic reaction to vaccine or vaccine component)
   b. Afraid Of Needles _____
   c. Religious Belief _____
   d. Afraid of Getting the Flu _____
   e. Choose Not to Consent _____
   f. Other Reason _____
6. Please sign below

Thank you. This survey is Complete.

Observer Signature _____ **Date:** _____

BROWARD HEALTH

NORTH BROWARD HOSPITAL DISTRICT
d/b/a BROWARD HEALTH

MEDICAL STAFF OBSERVATIONAL EXPERIENCE CHECKLIST

Region:_____ Date:_____

Observer Name:_____

Date of Birth:_____ Cell Phone Number:_____

Sponsoring Physician:_____

The Medical Staff Office has reviewed the following documents and made the subsequent determinations prior to presenting to Hospital Senior Executive for review, approval decision, and signature:

Document	Satisfactorily Completed? Circle (Y), (N)		Comments
Observational Experience Applicant Checklist	Y	N	
Observational Experience Request and Agreement	Y	N	
Observational Experience Sponsoring Physician Agreement	Y	N	
Observational Experience Acknowledgement	Y	N	
Observational Experience Influenza Vaccine Survey	Y	N	
Copy of Observer's current government-issued ID	Y	N	
Copy of Observer's health insurance card	Y	N	
Certificates of Completion of all required orientation modules	Y	N	
Negative TB test or negative chest x-ray	Y	N	
Confidentiality and Data Security Agreement	Y	N	
Copy of Covid-19 Vaccine Card	Y	N	

File Reviewed by Medical Staff Representative:

_____

Signature Print Name Title Date