

ATTACHMENT "C"



**OBSERVATIONAL EDUCATION PROGRAM AGREEMENT**

Creighton University Medical Center is committed to quality health care and confidentiality for its patients. As part of its commitment to patient care, Creighton provides a learning environment for future health care providers.

As a participant in Creighton's Observational Education Program ("Program"), which provides learning through observation of patient care, I, the undersigned, agree to the terms of this Agreement. I have been given the opportunity to review this statement and my questions have been answered.

"Confidential Information" is any patient, physician, employee, and Creighton business information obtained during the course of work or association with Creighton University.

I understand that my participation in the Program is observational only. I will not provide or participate in patient care in any manner. I will not physically touch patients at any time. I understand that my access to patient care settings is subject to termination at the request of patients. I agree to cooperate with all instructions from my Sponsor as well as any other clinical or administrative staff.

I agree to treat all Confidential Information as strictly confidential and will not reveal or discuss Confidential Information with anyone who does not have a legitimate medical and/or business reason to know the information. I understand that I am permitted to access Confidential Information only to the extent necessary for my participation in the Observational Education Program. I will not disclose identifiable Confidential Information (e.g., name, date of birth) to any person other than my Sponsor for any purpose whatsoever. I will not access or disclose Confidential Information for personal purposes.

I understand that I will not be given and must not accept electronic security codes or passwords. I agree not to breach the security of the information systems or premises. I will not use or disclose or misuse security codes or passwords, if I obtain or receive any. I will not misuse or attempt to alter Creighton University Medical Center (CUMC) information systems in any way.

I will abide by all Creighton University Medical Center policies and procedures regarding Confidential Information. I understand that violations of CU and/or CUMC policy may subject me to immediate termination of my assignment at CUMC, as well as civil sanctions and/or criminal penalties.

My signature acknowledges that I have read and understand this Agreement.

Program Participant Name (print)

\_\_\_\_\_ Date

Program Participant Signature

\_\_\_\_\_ Assigned department