Steward Health Care Privacy Agreement

• Employees • Medical Staff • Fellows/Residents Students/Interns • Contracted Workforce Members • Volunteers

This Agreement describes your responsibilities as it relates to protecting privacy at Steward Health Care.

I, _____ *(please print name)* understand that, in my role at Steward Health Care ("Steward"), I may access or be privy to Confidential Information, as defined below, as part of my employment/assignment/affiliation with Steward. As part of my responsibility to safeguard Confidential Information I understand and agree to the following:

- It is my responsibility to maintain the confidentiality of all Protected Health Information ("PHI"), human resource, payroll, fiscal, management, and any other non-public information that could subject the organization, the data owner, or the data subjects, to harm (including but not limited to financial damages, embarrassment, or damage to reputation) if the data were lost, stolen, accessed or acquired by unauthorized individuals ("Confidential Information").
- Not to access, use or disclose Confidential Information without a job-related reason to do so. I agree not to use or disclose Confidential Information for personal purposes and agree not to disclose PHI to any individual or entity that does not also have a job-related reason to access the Confidential Information.
- Not to make inquiries about Confidential Information for others who are not authorized to access it.
- When I access, use or disclose PHI, I will use the minimum necessary amount of PHI required to do the job.
- Not to copy or remove Confidential Information from Steward premises without authorization and applying appropriate safeguards. Nevertheless, I will do so only as related to performing my job duties.
- To take appropriate precautions, as defined by policy, when mailing or faxing Confidential Information including checking that the contents and address are correct.
- To maintain all paper Confidential Information securely (e.g. locked desk, locked file cabinet or locked office).
- Not to leave Confidential Information unattended in plain view in an area that is accessible to persons not authorized to view the Confidential Information.
- To avoid discussing Confidential Information in public areas such as lobbies, public hallways and elevators. When discussing Confidential Information, I agree to take appropriate precautions, such as lowering my voice, to prevent unauthorized individuals from hearing the information.
- To appropriately dispose of paper Confidential Information by shredding. Trash and recycling bins are not an acceptable method of disposal. Confidential Information may never be placed in a recycling container.
- To immediately report any known or suspected inappropriate access, use or disclosure following the entities incident reporting protocol or to the Office of Corporate Compliance & Privacy.
- To refer to the Steward Privacy Policies, as appropriate, for additional guidance on privacy-related matters.
- Violation of this Agreement or applicable privacy law or policy, may result in disciplinary action, up to and including termination of my relationship with Steward, in accordance with Steward policies.
- Violation of this Agreement may result in legal liability for me as well as Steward. I agree to indemnify Steward and its parent(s), affiliates, directors, trustees, medical staff, officers, employees or agents and assignees from any loss, damage, claim or liability including reasonable attorneys' fees arising out of my willful neglect or failure to exercise reasonable care which results in an unauthorized access, use or disclosure of Confidential Information in breach of this Agreement and in violation of applicable Steward policies.
- Upon termination of my relationship with Steward, I will immediately return any documents in my possession containing Confidential Information, in addition to any other required materials.
- My obligations under this Agreement continue after the end of my relationship with Steward.

By signing this document I certify that I have read the above Agreement and agree to comply with its terms.

Signature_____ Date_____

Steward Code of Conduct Attestation

I hereby acknowledge that I have read and understand the information set forth in the Steward Code of Conduct. I certify that I will comply with these standards in my daily work activities and that I have a responsibility to report any suspected violations of the Code. I understand adhering to these standards is a condition of employment or business relationship with Steward and that if I have any questions about the Code I must ask my manager for clarification and/or call the Office of Corporate Compliance & Privacy (OCCP). I certify that I will report to my manager and/or the OCCP any instances where I did not or was unable to comply with the standards set forth in the Code.

Signature_____ Date_____

Employee Health
2022-2023 SEASONAL INFLUENZA EDUCATION/CONSENT FORM (NORTH)

Name: **(PLEASE PRINT CLEARLY)**	**(PLEASE CHECK WHICH APPLIES)** ❑ Employee ❑Medical Staff ❑ Volunteer ☒ Student ❑ Other:
Date of Birth **(REQUIRED):**	Department/Job Title: Student

Please select your Steward Location(s). Check ALL that apply.

❑ Carney Hospital	❑ Holy Family Methuen	❑ New England Sinai	❑ St. Elizabeth's	❑ Corporate
❑ Good Samaritan	❑ Morton Hospital	❑ Norwood Hospital	❑ St. Anne's Hospital	❑ Other _____
❑ Holy Family Haverhill	❑ Nashoba	❑ Steward Medical Group		
❑ Sharon Regional	❑Trumbull Hospital	❑ Hillside Rehab		

Influenza Education

- For Influenza Season 2022-2023, I understand that it is a **condition of employment** to be immunized with the influenza vaccine unless I have one of the following contraindications:
  - Severe (life threatening) allergy to a prior dose of a seasonal influenza vaccine or to any component of the vaccine.
  - History of Guillian-Barre Syndrome within six weeks of receiving an influenza vaccine
  - Sincerely held religious Belief or observance that influenza vaccination is against a specific tenet of their faith.
- Influenza vaccination is recommended for all people 6 months of age and older.
- Influenza is a serious respiratory disease that kills an average of 36,000 persons and hospitalizes more than 200,000 persons in the United States in an average year.
- Complications from the flu can lead to pneumonia.
- If I contract influenza, I will shed the virus for 24-48 hours before influenza symptoms appear. My shedding the virus can spread influenza infection to patients in this facility.
- If I become infected with influenza, even when my symptoms are mild, I can spread severe illness to others.
- I understand that the strains of virus that causes influenza infection may change from year to year, however, even if the vaccine components are not changed, revaccination is necessary as protection from the vaccine does not last from one flu season to the next.
- I cannot get the influenza disease from the inactivated influenza vaccine.
- The hospital is offering me influenza vaccination free of charge.
- I have been offered the current Vaccine Information Statement. 8/6/2021 | 42 U.S.C. § 300aa-26

IMMUNIZATION STATUS:

☐ **I ALREADY RECEIVED the influenza vaccination for this flu season. I received vaccination on:**
Date: ____/___/___ at Location: _____.

☐ **I ACCEPT and wish to receive the Influenza vaccine unless valid contraindication is indicated**

Please complete the following:

Valid Contraindications:

YES	NO	
◯	◯	1. Had a severe (life-threatening) allergy to a previous dose of a seasonal influenza vaccine or to any component?
◯	◯	2. Is vaccination with influenza vaccine contrary to your religious beliefs and/or observances?
◯	◯	3. Have you ever had Guillain-Barre Syndrome within six weeks of receiving influenza vaccine?

Consider Alternative Vaccine Preparation:

◯	◯	4. Have you ever had an anaphylactic (severe allergic) reaction to eggs or egg products?
◯	◯	5. Are you allergic to latex?
◯	◯	6. Are you allergic to thimerosal (a preservative) other than contact lens sensitivity?

Signature: _____Date: _____

Office Use Only

❒ **Individual has contraindication to receive Influenza Vaccine as noted above**

❒ Administration of Appropriate **FLU VAX** Manufacturer: _____ Lot #: _____ Exp. Date:_____

Injection Site: ❒ Left deltoid ❒ Right deltoid Dose: 0.5ml

Signature:(NP/RN/LPN/MA) _____ Date : _____/_____/_____

Employee Health
COVID-19 Vaccine EDUCATION/CONSENT FORM

Name: **(PLEASE PRINT CLEARLY)**	**(PLEASE CHECK WHICH APPLIES)** ☐ Employee ☐ Medical Staff ☐ Contractor ☐ Other
Date of Birth **(REQUIRED):**	Department/Job Title/Contractor/Vendor Name:
Facility	

COVID-19 Education

- I understand that it is a **condition of employment** to receive the COVID-19 vaccine unless I have one of the following contraindications:
  - Severe allergic reaction to a previous dose of a COVID-19 vaccine or to any component of the vaccine.
  - Religious Beliefs requires note from clergy stating that immunization vaccination is against a specific tenet of their faith.
- COVID-19 vaccination is recommended for all Healthcare workers.
- COVID-19 is a serious respiratory disease that has killed over 3600 Healthcare workers within the first year and over 4.24 million people throughout the world.
- Complications from COVID-19 can lead to pneumonia, blood clots, autoimmune issues, heart problems, and organ failure
- If I contract COVID-19, I may be contagious up to 2 days before symptom onset and up to 5 days after. During this time period, I understand that I can spread the virus to patients and co-workers in this facility.
- The hospital is offering me the COVID-19 vaccination free of charge.

IMMUNIZATION STATUS:

☐ **I ALREADY RECEIVED the COVID-19 vaccination.**

☐ **A copy of the COVID-19 Vaccine Record Card attached to consent**

☐ **I ACCEPT and wish to receive the COVID-19 vaccine unless valid contraindication is indicated**

Please complete the following:

Valid Contraindications:

YES	NO	
☐	☐	1. Have you had a severe allergic reaction after a previous dose of a COVID-19 vaccine?
☐	☐	2. Have you had a severe allergic reaction to any ingredient in a COVID-19 vaccine?
☐	☐	3. Is vaccination with COVID-19 vaccine contrary to your religious beliefs and you have provided clergy documentation?

Signature: _____Date: _____

PLEASE CHECK ONE: FIRST ☐ or **SECOND** ☐ dose of the COVID-19 Vaccination

Office Use Only

❒ **Individual has contraindication to receive COVID-19 Vaccine as noted above**

❒ Administration of Appropriate **COVID vax** Manufacturer: _____ Lot #: _____ Exp. Date:_____

Injection Site: ❒ Left deltoid ❒ Right deltoid Dose: _____

Signature:(NP/RN/LPN/MA) _____ Date : _____/_____/_____