SALINA FAMILY HEALTHCARE CENTER

Medical 785-825-7251 | Dental 785-826-9017 | Pharmacy 785-452-3900 | Main Office 785-825-7251

Student/Visitor Name:_____ Profession:_____

Address/City/State/Zip:_____

Phone:_____ Email:_____ Gender: M F

Emergency Contact:_____ Relationship:_____

Phone:_____ Email:_____

Is this observation related to a school/college course? ☐ Yes ☐ No

If yes, please provide: The course name: _____

School: _____

Instructor: _____

Shadow Dates: _____ Person Shadowing:_____

Statement of Confidentiality

I (print name) _____ understand that while visiting and/or participating in special education projects, clinical experiences and other activities at Salina Family Healthcare Center, I may have access to information which is of a confidential nature. Because the learning activities are educationally beneficial, I am expected to respond at all times in a professional manner. Any information, either written or oral, having any relevance to patient care is strictly confidential. Discussions regarding patients and/or any Salina Family Healthcare business information are restricted to the proper professional environment under the supervision of appropriate personnel.

It is understood, that violation of that confidentiality, whether intentional or involuntary, may result in disciplinary action, up to and including termination from the practical experience at Salina Family Healthcare Center, and may result in civil and/or criminal liability.

By my signature, I verify that I have read the above information and agree to abide by Salina Family Healthcare Center's policies pertaining to HIPAA, patient confidentiality, and the confidentiality of business records.

_____ _____

Student Signature Date

_____ _____

SFHC Personnel Signature Date