Student Participation Agreement

I,_____("Student"), in consideration of participating in the education
(print name)
experience program provided by _____
("Organization"), through my participation in Organization's training program, hereby agree to the following:

1. I will comply with all applicable, policies, procedures, rules and regulations of Organization, and the instructions of Organization supervisors, including but not limited to, those governing patient confidentiality. I will further observe professionally appropriate modes of dress, behavior and grooming at all times.

2. I will participate in education and training opportunities in accordance with the instructions of Organization supervisors.

3. I understand and acknowledge that Organization has the right to take certain actions, including but not limited to, the right to suspend or terminate me from, or limit my participation in, the education experience program, or to evaluate me unfavorably, if in its exclusive judgment I have failed to observe applicable policies, procedures, rules, regulations, or the instructions of Organization supervisors, or have compromised the standard or quality of patient care or the safety of patients, or for other reasonable cause, including the failure to follow appropriate modes of dress, grooming and behavior. **I hereby voluntarily release Organization and its directors, officers, employees, agents and representatives from any and all liability based on such actions.**

4. I acknowledge that the educational experience received by me from Organization shall be received as a student at _____
(insert school name)
as a part of my professional training, and not as an employee of Organization. I understand that as a participant in this educational program, I shall not be entitled to compensation or employee benefits, nor shall I be considered an employee of Organization for purposes of unemployment compensation, minimum wage laws, workers' compensation, income tax withholding, Social Security benefits, or any other purpose or benefit.

5. I understand that any and all work product created or developed by me in the performance of my educational experience program at Organization shall be the sole and exclusive property of Organization and that I agree to abide by Organization's policies and procedures in such regard. I hereby irrevocably convey, transfer, and assign to Organization all right, title and interest in and to, including all intellectual property rights in and to, such work product, whether or not such work product is deemed a “work made for hire” under the Copyright Act. I irrevocably waive any and all claims I may now or hereafter have in any jurisdiction to so called “moral rights” with respect to the work product and shall provide to Organization all assistance reasonably required to perfect Organization’s and its affiliate's rights in the work product hereunder. Notwithstanding the foregoing, I understand I may use work product created or developed in the performance of an educational experience under this Agreement for the sole purpose of satisfying School course requirements and for no other purpose.

6. I understand and acknowledge _____
(insert school name)
shall have complete control over all academic aspects of the educational program, including but not limited to, admissions, administration, faculty appointments, program design, grading, examinations and evaluations. I hereby voluntarily release Organization and its directors, officers, employees, agents and representative from any and all liability based on such actions.

7. I understand Organization requires that I submit proof of immunizations to my School prior to the start of my educational experience at Organization. I understand also failure to submit such proof or receive a religious or medical exemption as applicable from my School will prohibit me from participating in an educational experience at Organization. Immunizations I must submit proof of receiving include: TB (or negative screening), Mumps, Rubella, Rubeola, Varicella Zoster, Hepatitis B Vaccine, Influenza and COVID-19. I understand that vaccines which are, or may be, seasonal in nature must be current prior to the start of my educational experience.

8. I have reviewed the Patient Rights Information.

9. I have read this Participation Agreement carefully and have had sufficient opportunity to ask questions and any of my questions were answered to my satisfaction before signing it.

_____ _____
Student's Signature Date

_____ _____
Guardian Signature if Student is a minor Date

Trinity Health
Of New England

CODE OF CONDUCT AND INTEGRITY AND COMPLIANCE ORIENTATION ACKNOWLEDGEMENT STATEMENT

This Code of Conduct is intended to promote high standards of patient care, business and ethical conduct in all activities involving all ministries and affiliates within Trinity Health Of New England (TH Of NE). TH Of NE is committed to compliance with all legal requirements, including full compliance with all Federal health care program requirements and the preparation and submission of accurate claims consistent with such commitment.

It is the policy of TH Of NE to conduct its operations as a model corporate citizen; to impose the highest ethical standards for all TH Of NE personnel; to maintain a zero tolerance for violations of applicable laws and regulations and the requirements of federal and state health programs, and for fraud, waste or abuse; and to enforce appropriate sanctions on those who violate these principles.

Refer to the Code of Conduct for more details.

☐ I have received, read, understand and will abide by the Trinity Health Of New England Code of Conduct.

☐ I have received the Trinity Health Of New England Integrity and Compliance Orientation and Code of Conduct document. I accept the responsibility to read, understand and abide by as is appropriate to my job responsibilities

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As Trinity Health Of New England personnel, you are required to certify in writing that you are not (i) currently excluded, debarred, suspended or otherwise ineligible to participate in the Federal health care programs or in Federal procurement or non-procurement programs, or (ii) been convicted of a criminal offense that falls within the ambit of the Civil Monetary Penalties Law (42 U.S.C. Section 1320a-7(a)), but has not been excluded, debarred, suspended or otherwise declared ineligible. You acknowledge that you are required to disclose immediately to the Integrity and Compliance Officer if you meet the above criteria.

☐ I certify that I do not meet the criteria as described above.

_____ _____

Signature Date

_____ _____

Print Name Employee# or Badge# (if applicable)

Trinity Health
Of New England

CONFIDENTIALITY AND NON-DISCLOSURE STATEMENT

Trinity Health Of New England (TH Of NE) and its affiliates, which are covered entities as defined under HIPAA regulations (referred to in this document as Trinity Health Of New England), have the legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their personal, health, financial and related information, referred to in this Agreement as "Protected Health Information." Therefore, Trinity Health Of New England requires that each of its providers, employees, residents, students, volunteers, business associates, contractors, vendors, agents and representatives maintain the confidential nature of Protected Health Information (PHI) and to abide by the specific policies of TH Of NE regarding the access to, disclosure of, and use of such information.

Protected Health Information, which is to be held confidential, is described in the Privacy Policies of TH Of NE. This includes both paper and electronic patient data stored throughout the organization or stored on computer systems.

As a condition of my employment or association with TH Of NE, and due to my ability to access and use patient information, I acknowledge and agree to the following:

I acknowledge that I have read the Confidentiality of Patient Information Policy of Trinity Health Of New England.

☐ I agree that I will keep confidential all PHI accessed or used in the course of performing my job functions, and I will not at any time during or after my employment, business relationship, or association with Trinity Health Of New England disclose PHI except in compliance with the Confidentiality of Patient Information Policy.

☐ I agree that I will not examine or make copies of any documents containing PHI unless there is a legitimate health care treatment or business need and appropriate protocols for accessing, disclosing or using such patient information have been followed. This includes making copies or downloading patient data that is stored in computer systems accessed in performing job functions. I understand that any requests to release PHI must be directed to Health Information Management or the appropriate department within Trinity Health Of New England.

☐ I agree to use discretion when PHI must be discussed with others in the course of my work, and I agree to take reasonable precautions to assure that such discussions cannot be overheard by others who do not have a need to know such information.

☐ I understand that PHI in any form shall not be removed from the facilities of Trinity Health Of New England or disclosed to unauthorized persons unless a legal authorization has been obtained or such disclosure is mandated by law. I understand that any requests to release PHI must be directed to Health Information Management or the appropriate department within Trinity Health Of New England.

☐ I agree to access only those specific elements of information for which I have legitimate access rights based on my assignment and responsibilities. I understand I cannot use my computer access to look up PHI that is not required to perform my job responsibilities. Curiosity or concern about an individual's condition does not constitute a legitimate need to access a record.

☐ I agree to keep my password(s) confidential and not share it (them) with any individual or allow any individual to access information through my password(s). I understand that my password(s) will be changed periodically to help maintain security of the systems.

☐ I agree to follow policies related to the use of email. I understand that it is strictly prohibited to use email that includes, but not limited to the following activities: illegal or fraudulent, offensive or obscene, annoying or harassing, or on behalf of other organizations.

☐ I agree to follow policies and procedures that govern the use of computer software. I will comply with all applicable software licenses and copyright laws and will take reasonable precautions to protect the hospital from computer viruses.

☐ I have read all of the above sections of this agreement and I understand that violation of this agreement may result in disciplinary action, up to and including termination. In addition, I may be subject to federal or state laws which include fines and/or imprisonment and/or reporting the breach of confidentiality to professional licensing boards.

Name (Print) :	Employee# or Badge# (if applicable):
Department Name & Number or Organization/Company Name:	
Signature : Date:	
Manager Name and Department (Print)	Manager Employee#
Signature : Date:	

Trinity Health
Of New England

CONFLICT OF INTEREST DISCLOSURE FORM

Name: _____ Title: _____

Organization/Department: _____ / _____ Contact#: _____

The purpose of this form is for you to disclose any interest or affiliations that you or a family member(s) may have that, when considered in light of your position within or relationship to **Trinity Health** may potentially create a conflict of interest (see examples on following page).

*Please disclose your interests and affiliations with **Trinity Health or its Ministry Organizations, and other related organizations referred to herein as the Unified Enterprise Ministry (UEM)** in one of the following boxes:*

- ☐ I do not have any conflicts of interest with the **Trinity Health UEM**. Neither do any family members
- ☐ I do have a conflict/family member have a conflict ***(describe below)*****
- ☐ I or a family member **may have** a conflict/not sure ***(describe below)*****

Please describe the actual or potential conflict of interest below:

_____

_____

_____

_____

_____

_____

_____

_____

Signature: _____ **Date:** _____

*** Potential and Actual Conflicts of Interest will be reviewed by the Integrity and Compliance Department and also Legal Services for Trinity Health Of New England. All potential or actual conflicts should be reported to the Integrity and Compliance Officer.**

Trinity Health
Of New England

POTENTIAL CONFLICTS OF INTEREST

- **IN GENERAL**: Medical staff members may not engage in any personal, business or professional activity which conflicts with the duties and responsibilities of their position within the organization.

- **ENDORSEMENTS AND TESTIMONIALS:** Suppliers, vendors, trade and professional organizations, and others may seek an endorsement or testimonial from medical staff members of Trinity Health. Medical staff members cannot agree to perform such endorsements or testimonials without prior written approval from the Department Chair, VP of Medical Affairs, Local Integrity Officer, or CEO.

- **FINANCIAL INTERESTS:** Except for investments in large, publicly traded companies, medical staff members should disclose financial relationships to Trinity Health, medical staff leadership, and patients that could create a risk that professional judgment or actions regarding a primary interest (patient care, research, medical education) will be unduly influenced by personal, family, or friends' gain.

- **Medical staff members may not do business with, or on behalf of Trinity Health**, or recommend that Trinity Health do business with a company in which the medical staff member or immediate family member has a financial interest or business relationship without first disclosing such relationship to the Department Chair, VP of Medical Affairs, Local Integrity Officer, or CEO.

- **If a medical staff's family member works for a vendor, contractor, customer or competitor**, and is in a position to influence the medical staff member's decisions affecting Trinity Health with that vendor, contractor, customer or competitor, the medical staff member must promptly disclose the family member's position to his/her Department Chair, VP of Medical Affairs, Local Integrity Officer, or CEO.

- **A conflict of interest may arise when a medical staff member serves as a board member** for an outside organization that does business with or seeks to do business with Trinity Health. Public service is encouraged, but such positions must be disclosed to the medical staff member's Department Chair, VP of Medical Affairs, Local Integrity Officer, or CEO.

- **Unless otherwise directed by Trinity Health,** when speaking on public issues or as a member of an outside organization, medical staff members should not give or permit the appearance that they are speaking on behalf of Trinity Health.

- **When serving as a member of an outside organization or in public office**, medical staff members should consider abstaining from any decisions or discussions that could affect Trinity Health. The medical staff member should make the reason for abstaining clear to the outside organization or to the applicable public officials and advise his/her Department Chair, VP of Medical Affairs, Local Integrity Officer, or CEO about such matter.

- **SELF-DEALING**: Actions disloyal to the organization for personal gain are called "self-dealing" and are prohibited. Examples of self-dealing are stealing, or disclosing proprietary information so that you, a friend, an associate, or a family member may obtain a profit or other advantage.

- **VENDORS and PHARMACEUTICAL INDUSTRY**: Medical staff members are expected to maintain objective relationships with all current and potential health industry and pharmaceutical representatives. Medical staff members must not exert, or appear to exert, special influence on behalf of an industry representative or potential representative because of friendship or any other relationship. Medical staff members must disclose potential conflict of interest/relationships to Trinity Health, medical staff leadership, and as applicable to patients who are or may use these products.

- **OUTSIDE EMPLOYMENT**: Employment or medical staff membership with outside entities must not interfere or conflict with the performance of the medical staff member's duties at Trinity Health.

- **CONFIDENTIAL INFORMATION**: The use of confidential, non-public information for personal advantage is prohibited.