CARROLL HOSPITAL
a LifeBridge Health center

CONFIDENTIALITY AND RESPONSIBILITY AGREEMENT

I understand that as an associate, member of the medical staff, physician office employee, or non-Carroll Hospital Center patient care provider or support personnel (volunteer, intern, student, contractor, vendor, etc.) of Carroll Hospital Center (Carroll Hospital Center) the performance of my duties may require me to access or become aware of confidential information, such as:

• Patient health care information (otherwise known under HIPAA as Protected Health Information or Electronic Protected Health Care Information) and financial information.

• Associate personnel, compensation and health care information

• Physician performance and personnel information

• Business information relating to Carroll Hospital Center (including financial, administrative, resource management, and other information)

By signing below, I agree to the following:

a. I understand that approval to access and use this information in verbal, written, or electronic (stored in computer) form is a privilege. I also understand that access to Carroll Hospital Center information is permitted based only on business or clinical "need to know" standards and the responsibilities of my duties as an associate, member of the medical staff, or non-Carroll Hospital Center patient care provider or support personnel (as defined above). I agree to access information only on patients for whom I, my office, area, or department has responsibility. Patient information may be used for research or teaching purposes only when authorized by the appropriate institutional review board and in compliance with Carroll Hospital Center policies and procedures.

b. If part of the information access privilege extended to me by Carroll Hospital Center includes the use of a computer workstation including the use of Internet or internal e-mail or Internet access that I will exercise this privilege in accordance with the relevant policies and procedures of Carroll Hospital Center. I understand further that there is no expectation of privacy with respect to e-mail. I also understand that Carroll Hospital Center has provided access to the Internet for authorized users only to support the business purposes of Carroll Hospital Center.

c. I understand that the methods I use to obtain PHI or financial information may only be used in the performance of my duties. I understand that if granted a sign-on code, password, Personal Identification Numbers (PIN) and/or "physical token device" that I accept full responsibility for any use or actions taken with my sign-on code(s), password(s), physical token device or (PIN's), and recognize that, in some cases, these codes are the equivalent of my signature The codes will be used only by me and I agree that I will not use another person's codes, passwords, PIN's or tokens at any time. I will notify the Carroll Hospital Center HIPAA Security Office should my code(s) be compromised in any way, or if my token is lost or stolen. I will reimburse Carroll Hospital Center for the cost of the token, if not recovered. Violation of this Agreement will result in For Physicians: disciplinary action up to and including dismissal from the Medical Staff and/or House Staff of the Hospital; For Associates: disciplinary actions including immediate dismissal under the guidelines of the Carroll Hospital Center Human Resources and HIPAA Policies and Procedures; For Non-Associates: disciplinary actions up to and including immediate termination of your relationship with Carroll Hospital Center. In addition, violation of this Agreement may result in possible legal action, fines or criminal prosecution against you and the organization you represent.

d. I understand that I may not seek access to any information that is not required to perform my duties. I understand that an audit trail, noting my code(s) or PINs, the patient, or system accessed, and the date may be inspected and reviewed by Carroll Hospital Center. I understand that PHI accessed through the computer is considered the same as the patient's medical record and may not under any circumstances be re-disclosed without proper authorization as covered in Carroll Hospital Center's By-laws, Policies and Procedures. I agree to access, use, store and dispose of information, which I am exposed to in a way that ensures continued security and confidentiality in accordance with Carroll Hospital Center Policies and Procedures.

e. I understand that computer hardware, software, and information are considered Carroll Hospital Center property and are subject to and protected by appropriate Carroll Hospital Center Policies and Procedures.

f. I understand that Carroll Hospital Center has the right to modify its access program including revoking codes and requesting the return of any token access devices.

I understand my access privileges will be revoked if any of the above provisions are violated.

Signature: _____ Date: _____

Print Name: _____ Affiliation: _____

Date of Birth: _____ SS #: _____

CARROLL HOSPITAL
a LifeBridge Health center

I _____ am familiar with the OSHA/MOSH Blood Borne pathogens regulations and accept the responsibility for following Carroll Hospital's Safety and Protective practices in compliance with OSHA/MOSH regulations.
Any "exposure" that occur will be reported, at the time of the exposure, to Carroll Hospital and my employer. I understand that the institution will provide post exposure care.

Name: _____

Date: _____

CARROLL HOSPITAL
a LifeBridge Health center

Student Smoking Attestation

Carroll Hospital is committed to having a workforce that models a healthier lifestyle for our patients, community and affiliates. A healthier workforce means better care for our patients as well as setting an example for our communities. We believe this will motivate our patients to make positive lasting changes for their health.

Please write your name and sign the following pledge:

I, _____, hereby attest that I will not use smoking products (products intended for human consumption- chewed, smoked, dissolved, inhaled, snorted, sniffed or ingested by any other means, including e-cigarettes) while in the role of a student, in any capacity for the entirety of my rotation. This includes the entire hospital campus and all Carroll affiliated offices.

I pledge to support Carroll Hospital's and its affiliates' commitment to the health of our community to be a smoke-free and nicotine-free campus.

I understand that if I am caught smoking or if smoke is detected on my person in any form, I will be sent home immediately and offered no future clinical rotations provided by Carroll Hospital or Carroll Health Group.

Signature: _____

Date: _____

CARROLL HOSPITAL
a LifeBridge Health center

Certificate of Completion

This certificate is verification that I have reviewed the entire 2025 - 2026 Student Orientation Packet and I am accountable for the information

Name: _____

Signature: _____

Date: _____