KAISER PERMANENTE®

2870 CONFIDENTIALITY AGREEMENT

Instructions: 1. To ensure efficient and effective service, submit form online. Immediate confirmation will be sent to you upon receipt of your online submittal.
2. If online submittal is not feasible, fax your form to National HR Service Center (877) 477-2329 or interoffice mail to National HR Service Center, Alameda.
3. Remember to print copy of form before submitting.
4. The Effective Date represents the date the Confidentiality Agreement is signed.

* Employee ID	* Work Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
* Employee First Name	Employee Middle Name	* Employee Last Name
* Job Title	* Location	

AGREEMENT

In my job, I may see or hear confidential information in any form (oral, written, or electronic) regarding:

- HEALTH PLAN MEMBERS AND PATIENTS AND/OR THEIR FAMILY MEMBERS (such as patient records, test results, conversations, financial information)
- EMPLOYEES, PHYSICIANS, VOLUNTEERS, CONTRACTORS (such as employment records, corrective actions/disciplinary actions)
- BUSINESS INFORMATION (such as member rates, marketing plans, financial projections)

I will protect the confidentiality of this information. Access to this information is allowed only if I need to know it to do my job.

I AGREE THAT:

1. I will protect the privacy of our patients, members, and employees.
2. I will not misuse confidential information of patients, members, employees or Kaiser Permanente (including confidential business and personnel information) and I will only access information I have been instructed or authorized to access to do my job. With respect to Protected Health Information, I will only access or use such information as it is necessary to provide medical care to the member and/or patient or as necessary for billing and payment or health plan operations.
3. I will not access my family members' PHI. I will not access my own electronic medical records unless my job duties permit me to have access to electronic medical records (for example, KP HealthConnect). Instead, I will follow the same procedures that apply to non-employee health plan members.
4. I will not share, change, remove or destroy any confidential information unless it is part of my job to do so. If any of these tasks are part of my job, I will follow the correct department procedure or the instructions of my supervisor/chief of service (such as shredding confidential paper). If a demand is made upon me from outside Kaiser Permanente to disclose confidential information, I will obtain approval from my supervisor before disclosing such information.
5. I understand that inappropriate or unauthorized access, use or disclosure of PHI may result in legally required reporting to governmental authorities, including my name.
6. I know that confidential information I learn on the job does not belong to me and that Kaiser Permanente may take away my access to confidential information at any time.
7. If I have access to electronic equipment and/or records, I will keep my computer password secret and I will not share it with any unauthorized individual. I am responsible if I fail to protect my password or other means of accessing confidential information.
8. I will not use anyone elses password to access any Kaiser Permanente system unless I am authorized to do so. If I am authorized to do so (e.g., in order to perform computer systems maintenance), I will follow procedures to ensure the password is changed and that confidential information is not at risk.
9. I will lock my computer when I step away to prevent someone else accessing the computer under my logon. I understand that I am personally responsible for any accesses under my logon.
10. If I leave Kaiser Permanente I will not share any confidential information that I learned or had access to during my employment.
11. On termination of my employment, I will promptly return to Kaiser Permanente all originals and copies of documents containing Kaiser Permanente's information or data in my possession or control, unless the documents were provided to me as part of my employment record.

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist

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KAISER PERMANENTE®

2870

CONFIDENTIALITY AGREEMENT

* First Name	Middle Name	* Last Name
* Employee ID	* Work Phone Number (###)###-####	* Effective Date (mm/dd/yyyy)

AGREEMENT - (Continued)

Examples of Breaches of Confidentiality (What you should NOT do.)

These are examples only and do not include all possible breaches of confidentiality.

- Unauthorized reading of patient account information.
- Unauthorized reading of a patient's chart.
- Unauthorized access to my own medical information if my job duties do not permit me to have access to electronic medical records (for example, KP HealthConnect).
- Accessing medical information of friends, co-workers, family members, or anyone else, unless it is required for my job.
- Discussing confidential information in a public area such as a waiting room or elevator.
- Discussing or otherwise sharing confidential information with anyone in your personal life, including family members or friends.
- Accessing records for any reason other than for legitimate business purpose.
- Accessing records of family, friends, co-workers, patients in the media, well known political figures, celebrities, or anyone else about whom you are curious.
- Sending confidential information to your personal e-mail account, unless you are authorized to do so and the information is transmitted in accordance with required procedures (e.g., encrypted).
- Saving confidential electronic information to a KP-owned or non-KP-owned flash drive, CD, or any other removable or transportable storage device unless you first secure permission as outlined in the Secure Electronic Storage provisions of the KP Information Security Policy.
- Saving confidential electronic information to a KP-owned or non-KP-owned workstation, laptop computer, personal digital assistant, or any other mobile computing device unless you first secure permission as outlined in the Secure Electronic Storage provisions of the KP Information Security Policy.
- Using personal devices (digital cameras, camera phones) to take photographs that may include confidential information as the primary subject or in the background.
- Documenting or referencing confidential information on any social networking site, such as Twitter, My Space.
- Telling a co-worker your password so that he or she can login to your work.
- Telling an unauthorized person the access codes for employee files or patient accounts.
- Being away from your workstation while you are logged into an application, without locking your system to protect confidential information.
- Unauthorized use of a co-worker's password to logon to a Kaiser Permanente information system.
- Unauthorized use of a user ID to access employee files or patient accounts.
- Allowing a co-worker to use your secured application* for which he/she does not have access after you have logged in.

* secured application = any computer program that allows access to confidential information. A secured application usually requires a user name and password to log in.

KAISER PERMANENTE®

2870

CONFIDENTIALITY AGREEMENT

* First Name	Middle Name	* Last Name
* Employee ID	* Work Phone Number (###)###-####	* Effective Date (mm/dd/yyyy)

AGREEMENT - (Continued)

12. I understand that I am responsible for my access, use, or misuse of confidential information and know that my access to confidential information may be audited.
13. I understand that my supervisor/chief of service or other managers and/or the Compliance Hot Line are available if I think someone is misusing confidential information or is misusing my password. I further understand that Kaiser Permanente will not tolerate any retaliation because I make such a report.
14. I understand that patient privacy and security is included in various training programs within Kaiser Permanente (for example: New Employee training, Annual Compliance Training), and by taking such training, I understand the obligations of confidentiality. I further understand that it is my responsibility to secure guidance from my supervisor or manager in the event any questions exist relating to my obligations regarding confidentiality.
15. I understand that this policy is not meant to prohibit any protected rights provided for in the National Labor Relations Act (for represented employees).
16. I understand that failure to comply with this agreement may result in disciplinary action up to and including termination of employment or other relationship with Kaiser Permanente. I understand that I may also be subject to other remedies allowed by law.
17. I understand that I must also comply with any laws, regulations, and other Kaiser Permanente policies, including the Principles of Responsibility that address confidentiality.
18. By signing (or selecting the submit button below), I agree that I have read, understand, and that I will comply with this Confidentiality Agreement.

SIGNATURE (Required if not submitted online)

* Employee Signature

* Date (mm/dd/yyyy)

After completing the form:
1. Print form to keep a copy for your records.
2. Print another copy and sign it for your supervisor.
3. Press the Submit button.
4. Wait for a pop-up screen to confirm the form has been submitted. (This may take a few minutes.)
5. Submit online or fax your form to National HR Service Center (877) 477-2329 or interoffice mail to National HR Service Center, Alameda.

KAISER PERMANENTE®

2860 CHILD ABUSE REPORTING REQUIREMENTS

Instructions: 1.To ensure efficient and effective service please, submit form online.
2. Items marked with an asterisk (*) are required fields.
3. Remember to print copy of form before submitting.
4. Immediate confirmation will be sent to you upon receipt of your online submittal.

* Employee ID	* Home Phone (###) ###-####	* Work Phone (###) ###-####	* Effective Date (mm/dd/yyyy)

* First Name	Middle Name	* Last Name

1. REQUIREMENTS

Section 11166 of the Penal Code requires any child care custodian, health practitioner, or employee of a child protective agency who has knowledge of or observes a child in his or her professional capacity or within the scope of his or her employment who he or she knows or reasonably suspects has been the victim of child abuse or who he or she knows or reasonably suspects that a child is suffering serious emotional damage or is at substantial risk of suffering serious emotional damage to report the known or suspected instance of child abuse to a child protective agency immediately or as soon as practically possible by telephone and to prepare and send a written report thereof within 36 hours of receiving the information concerning the incident.

The identity of all persons who report shall be confidential and disclosed among agencies receiving or investigating mandated reports, to the district attorney in a criminal prosecution, or in an action initiated under Section 602 of the Welfare and Institutions Code arising from alleged child abuse, or to counsel appointed pursuant to subdivision (c) of Section 317 of the Welfare and Institutions Code, or to the county counsel or district attorney in a proceeding under Part 4 (commencing with Section 7800) of Division 12 of the Family Code or Section 300 of the Welfare and Institutions Code, or to a licensing agency when abuse or neglect in out-of-home care is reasonably suspected, or when those persons waive confidentiality, or by court order.

"Health practitioner" includes physicians and surgeons, psychiatrists, psychologists, dentists, residents, interns, podiatrists, chiropractors, licensed nurses, dental hygienists, optometrists, or any other person who is licensed under Division 2 (commencing with Section 500) of the Business and Professions Code; marriage, family and child counselors, emergency medical technicians I or II, paramedics, or other person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code; psychological assistants registered pursuant to Section 2913 of the Business and Professions Code, marriage, family and child counselor trainees as defined in subdivision (c) of Section 4980.44 of the Business and Professions Code; state or county public health employees who treat minors for venereal disease or any other condition; coroners; paramedics; and religious practitioners who diagnose, examine, or treat children.

Volunteers whose duties include direct contact with and supervision of children are not mandated reporters, but are encouraged to report instances of child abuse and neglect.

Your department chief or supervisor should be notified whenever you believe you may be required to report suspected child abuse.

I understand and agree, if in a "Child Care Custodian" or "Health Practitioner" classification, as defined above, to comply fully with the above-cited provisions of the California Penal Code, in accord with procedures established by my Employer/Medical Center.

2. EMPLOYEE SIGNATURE

Signature - (Required if not submitted online).

* Employee Signature	* Date (mm/dd/yyyy)

Facility / Department

After completing the form:
1. Print form to keep a copy for your records.
2. Press the Submit button.
3. Wait for a pop-up screen to confirm the form has been submitted. (This may take a few minutes.)

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772

KAISER PERMANENTE®

2862 DRUG-FREE WORKPLACE - EMPLOYEE ACKNOWLEDGEMENT

Instructions: 1. To ensure efficient and effective service, submit form online. Immediate confirmation will be sent to you upon receipt of your online submittal.
2. If online submittal is not feasible, fax your form to HR Service Center (877) 477-2329 or interoffice mail to HR Service Center, Alameda.
3. Remember to print copy of form before submitting.
4. The Effective Date represents the date the Drug-Free Workplace Employee Acknowledgement is signed.

* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
* First Name	Middle Name	* Last Name

1. EMPLOYEE INFORMATION

* Work Phone Number - Tieline (###) ###-####	* Work Phone Number - Outside (###) ###-####	NUID # (if known)
Location/Facility Name	Department	

2. ACKNOWLEDGEMENT

I understand that, as a provider of health care, Kaiser Permanente recognizes that alcohol and drug abuse/chemical dependency is a chronic disease and major health problem that can have tragic consequences for individuals, families, and the workplace.

As a condition of employment, all employees are expected to abide by the organization's policy which prohibits the use and/or abuse of drugs and alcohol in the workplace.

By my signature below, I acknowledge, understand, accept, and agree to comply with this policy. I also understand that failure to comply with this policy will result in corrective/disciplinary action, up to and including termination of employment.

DRUG-FREE WORKPLACE ATTESTATION

- I have received a copy of the policy NATL.HR.030, Drug-Free Workplace.
- I have read, understood, and familiarized myself with this policy, and understand that Kaiser Permanente is committed to providing a drug-free workplace.
- I understand that it is my responsibility to comply with this policy, and that this policy applies to me.
- I agree to abide by the terms of the policy, as a condition of employment.
- I understand that violations of this policy will subject me to corrective/disciplinary action, up to and including termination of employment.
- If I have any questions about this policy, I will seek clarification from my manager or a KP HR Representative.
- I understand that, in acknowledgment that chemical dependency is a chronic disease and that rehabilitative treatment is available, KP supports and strongly encourages employees with such problems to seek treatment, and will provide it when conditions and circumstances warrant.
- I understand that the responsibility for seeking, obtaining, and cooperating in such treatment is mine.
- I understand that, if I am experiencing alcohol or drug dependency, I am urged by the organization to make use of KP's confidential Employee Assistance Program, and/or such disability plans, rehabilitation programs, and health coverage plans that may be appropriate.

3. EMPLOYEE SIGNATURE (Required if not submitted online)

* Employee Signature	* Date (mm-dd-yyyy)

HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist

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KAISER PERMANENTE®

2862 DRUG-FREE WORKPLACE - EMPLOYEE ACKNOWLEDGEMENT

* First Name	Middle Name	* Last Name
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)

After completing the form:

1. Print form to keep a copy for your records.
2. Print another copy and sign it for your supervisor.
3. Press the Submit button.
4. Wait for a pop-up screen to confirm the form has been submitted. (This may take a few minutes.)
5. Submit online or fax your form to the HR Service Center (877) 477-2329 or interoffice mail to HR Service Center, Alameda.

HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist

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KAISER PERMANENTE®

2950 ELDER AND DEPENDENT ADULT ABUSE REPORTING REQUIREMENTS

Instructions: 1. To ensure efficient and effective service please, submit form online.
2. Items marked with an asterisk (*) are required fields.
3. Remember to print copy of form before submitting.
4. Immediate confirmation will be sent to you upon receipt of your online submittal.

* Employee ID	* Home Phone (###) ###-####	* Work Phone (###) ###-####	* Effective Date (mm/dd/yyyy)
* First Name	Middle Name	* Last Name	

1. ELDER AND DEPENDENT ADULT ABUSE REPORTING REQUIREMENTS

California Welfare and Institutions (W&I) Code Section 15659 requires Kaiser Permanente Medical Program to provide all "health professionals" and "care custodians" information concerning their responsibility to report incidents of observed, known, or suspected elder and dependent abuse. All health practitioners or care custodians must sign a statement acknowledging receipt and understand of the **mandatory** elder and dependent abuse reporting requirements. Kaiser Permanente must retain the signed statement.

Elders are persons 65 years of age or older. **Dependent adults** are persons between the ages of 18 and 64 with physical or mental limitations such as physical or developmental disabilities or age-diminished physical or mental abilities. The law also expressly includes any person between the ages of 18 and 64 who is admitted as an inpatient to an acute care hospital or other 24-hour facility as a dependent adult. (W&I Code Sections 15610.23, 15610.27 and 15701.2)

Abuse of and elder or dependent adult means either of the following:
(a) Physical abuse, including lewd or lascivious acts, neglect, financial abuse, abandonment, isolation, abduction, or other treatment with resulting physical harm or pain or mental suffering; or
(b) The deprivation by a care custodian of goods or services that are necessary to avoid physical harm or mental suffering. (W&I Code Section 15610.07)

At Kaiser Permanente, a physician, nurse, and licensed or unlicensed health care professional, including administrative and support staff, who, in his or her professional capacity, or within the scope of his or her employment, has observed or has knowledge of elder and/or dependent abuse, or reasonably suspects elder and/or dependent abuse, **shall report by telephone immediately or as soon as practically possible and by written report within two (2) working days** as follows:
(a) to the long-term care ombudsmen or the local law enforcement agency when the abuse is alleged to have occurred in a long-term care facility;
(b) to the State Department of Mental Health, the State Department of Developmental Services, or the local law enforcement agency if the abuse is alleged to have occurred in a state mental health hospital or state developmental center; or,
(c) to the adult protective services agency or the local law enforcement agency when the abuse is alleged to have occurred anywhere else. (W&I Code Section 15630)
All incidents should be documented and forwarded to the appropriate agency in accordance with local medical center procedures.

I certify that I have read and understand this statement and will comply with the requirements of the Elder and Dependent Abuse Reporting Law.

2. SIGNATURE

* Employee Signature	* Date (mm-dd-yyyy)
Facility / Department	

After completing the form:
1. Print form to keep a copy for your records.
2. Press the Submit buttion.
3. Wait for a pop-up screen to confirm the form has been submitted. (This may take a few minutes.)

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772

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KAISER PERMANENTE
HEALTHCONNECT

CONFIDENTIALTY AND NON-DISCLOSURE AGREEMENT

This CONFIDENTIALTY AND NON-DISCLOSURE AGREEMENT (the Agreement) is made between Kaiser Permanente (Kaiser Permanente) and the undersigned (you). This Agreement applies to your use of Kaiser Permanente's electronic medical record system, KP HealthConnect™, and related training materials to carry out your obligations and duties at your assigned Kaiser Permanente Medical Center. KP HealthConnect™ is a Kaiser Permanente trademark.

1. KP HealthConnect™ contains confidential information and proprietary materials owned by Kaiser Permanente and its licensors, such as Epic Systems Corp. The information and materials available in KP HealthConnect™ do not belong to you.

2. You must not print, transmit, download, transfer or make copies of any information, software or screen shots in this training.

3. You must protect the confidentiality of information in KP HealthConnect™ as required by State and Federal law.

4. You must use the KP HealthConnect™ user account assigned to you only if and when you need the information in KP HealthConnect™ to perform your work in the ordinary course of your assignment in providing services to Kaiser Permanente members and patients. You must not use KP HealthConnect™ user account for any personal or other purpose.

5. You must safeguard and keep your KP HealthConnect™ user ID and password secret. Sharing KP HealthConnect™ user ID and password with any other person, including co-workers or supervisors, is strictly prohibited. You must not use any other person's user ID and password to access any Kaiser Permanente system.

6. Kaiser Permanente may monitor your use of KP HealthConnect™ and your KP HealthConnect™ user account. You are personally accountable for any actions taken using the KP HealthConnect™ user ID issued to you.

7. You cannot share or exchange any confidential information with other personnel working at your hospital or facility unless it is required for you to perform your work. If any such sharing or exchange is required, you must follow the correct department procedure and the instructions of your supervisor/ chief of service (such as shredding confidential papers).

8. If you receive a request or demand from any person or organization other than Kaiser Permanente for confidential information or access to KP HealthConnect™, you must promptly notify your supervisor and Kaiser Permanente.

9. Your failure to comply with these obligations may result in the revocation of your KP HealthConnect™ user account and other actions by your employer or Kaiser Permanente.

10. On termination of your placement with Kaiser Permanente, you must return to Kaiser Permanente all copies of documents containing Kaiser Permanente's confidential information in your possession or control.

I UNDERSTAND AND AGREE TO COMPLY WITH THE TERMS STATED IN THIS CONFIDENTIALTY AND NON-DISCLOSURE AGREEMENT.

Print Name Sign Name Today's date

KAISER PERMANENTE®

FACILITY: _____

TITLE: Compliance / HIPAA Security Program

Instructions: Complete the fields below. **PRINT CLEARLY.**

Your Information		
LAST NAME	FIRST NAME	MIDDLE INITIAL
NUID #		
Primary Phone #	Alternate Contact #	
NURSING UNITS:	SCHOOL:	
Instructor Information		
LAST NAME	FIRST NAME	PHONE #

Completion Attestation

I understand that required compliance training is an important part of Kaiser Permanente's compliance program.

My signature indicates that I, and no one on my behalf, have completed the **General Compliance for Students.**

Principles of Responsibility Attestation

- I understand that the principles discussed in Kaiser Permanente's *Principles of Responsibility* apply to me.
- I have read, understood, and have familiarized myself with the *Principles of Responsibility*.
- I understand that I am expected to comply with Kaiser Permanente's security policies.
- If I have any questions about the *Principles of Responsibility*, I will seek clarification from the school liaison or the clinical site Nursing manager.
- I understand that I am expected to conduct myself in an ethical and responsible manner at all times, in accordance with the *Principles of Responsibility*.
- In addition to complying with *the Principles of Responsibility*, I understand that I am also required to report any suspected compliance or ethics concerns I become aware of. I further understand that I am protected from retaliation for reporting any such concerns.

Privacy and Security Compliance Attestation

- I have a responsibility to protect the privacy and security of member/patient identifiable information (MPII) and protected health information (PHI).
- I must assess the risks to the privacy and security of MPII/PHI in my work environment and take steps to reduce those risks.
- I should seek assistance from my Regional Privacy and Security Officer or Compliance Officer if I have questions about what my job and the law allows me to do.
- I should report to my instructor/supervisor, Privacy and Security Officer, Compliance Officer or Compliance Hotline if I suspect that someone is not following the law or policy.

X

SIGNATURE **DATE COMPLETED**

KAISER PERMANENTE
Staff Education & Development
Southern California

Kaiser Permanente Orange County - **Badge Instructions**

Complete the requested information below.

Name: _____ DOB: _____

Email: _____ Cell # _____

School: _____ Instructor Name: _____
(If applicable)

Read and Sign

Your signature below signifies your understanding of, and compliance with, the following:
KP student badges must be returned on the last day of unpaid field experience training to a locked badge box located on the wall outside of the **Professional Development & Education** department at either Anaheim or Irvine Medical Centers. Students may return badges to either location, but this must be done on the last day of rotations. No exceptions. Hospitals have open access 24/7 for badge return.

_____ _____
Signature Date

Obtain Badge

After you've received notice that you have been officially cleared for your student rotation, you may go to either of the **Security offices** listed below to obtain your badge.
Please bring your CA Drivers License with you.

Anaheim Medical Center
MOB 2
3430 E. La Palma
Anaheim, CA 92806
1st floor near Pharmacy & Lab

Irvine Medical Center
MOB 2
6650 Alton Pkwy
Irvine, CA 92618
1st floor behind Reception & near Lab

Office hours: Monday - Friday, 8 AM-4:30 PM

Return Badge

On the last day of your student rotation, return your badge to the badge drop box at either of the **Professional Development & Education offices** listed below:

Anaheim Medical Center
6th Floor of main hospital
3440 E. La Palma
Anaheim, CA 92806

Irvine Medical Center
6th Floor of main hospital
6640 Alton Pkwy
Irvine, CA 92618

Office hours: Monday - Friday, 8 AM-12 PM & 1 PM-4:30 PM

KAISER PERMANENTE
Professional Development & Education
Southern California

Kaiser Permanente Orange County

Employee Student/Faculty Rotation Approval Attestation

I authorize the employee named below to complete their unpaid field experience and training, (as a student or faculty), in the unit/department for which they work. I attest that I will perform the following, (please check each box indicating that you agree):

- ☐ Inform and confirm with local Human Resources (HR) of the intent for an employee to participate as a student/faculty as unpaid field experience personnel and obtain approval where warranted.
- ☐ Monitor access to pharmaceuticals and protected health information in collaboration with onsite faculty.
- ☐ Review KP data and/or information that student intends to use for program submissions and include any pertinent stakeholders to review the data/information prior to any approvals given in collaboration with faculty.
- ☐ Follow procedural steps for any research and/or quality improvement programs that student requests to perform. I will include pertinent stakeholders in the review of any requests. *(Request process is on schedule B in Student Unpaid Field Experience and Training policy).*
- ☐ Issue and retrieve any KP SCAL assets issued as part of the student rotation, when the asset is no longer needed.
- ☐ Report suspicions of unethical practice or wrongdoing to the appropriate personnel, (i.e. privacy breaches to local Compliance, intoxication to local HR).
- ☐ Assist student/faculty in obtaining accesses that are required for rotation if/when appropriate.

STUDENT or FACULTY INFORMATION

Name: _____ NUID: _____

☐ Student ☐ Faculty

School: _____ Accesses needed: ☐ Other _____ ☐ Pyxis ☐ Med Room ☐ Building

MANAGER INFORMATION

Name: _____ _____

Print *Signature*

Dept: _____ Location: _____ Date: _____

MOB/Med Center

KAISER PERMANENTE
Professional Development & Education
Southern California

Kaiser Permanente ORANGE COUNTY

Required Reading, Modules & Forms specific to Orange County

ATTESTATION

In addition to the requirements listed on the main page of this site, KP Orange County requires the following:

Please read, complete and sign where indicated.

REQUIRED READING

- ☐ Dress Code
- ☐ Infection Control

REQUIRED KP LEARN MODULES

Include Completion Certificates in Student Packet. *See Student Packet List for current course number.*

To be completed by all

- ☐ Orange County Annual Training and Review
- ☐ Safe Patient Handling

To be completed by RNs & Faculty only

- ☐ Health Connect
- ☐ Glucometer Validation

To be completed by Faculty only

- ☐ Pyxis MedStation ES System Tutorial

REQUIRED FORMS

Include completed and signed forms in Student Packet.

- ☐ Badge Instructions
- ☐ OPTIONAL-Required of Students/Faculty on designated home unit only
- ☐ Attestation

ATTESTATION

I hereby affirm that I have read and completed the **KP Orange County Required Readings, Modules & Forms** listed on page 1 of this document. Any such misrepresentation, misstatement, or omission, whether intentional or otherwise, may result in immediate suspension or termination of program participation with Kaiser Permanente.

_____ _____

Print Name Signature

_____

Date

KAISER PERMANENTE
Professional Development & Education
Southern California

Kaiser Permanente Orange County
Required Reading Attestation

Complete the requested information below.

Name: _____ DOB: _____

Email: _____ Cell: _____

School: _____ Instructor Name: _____

KPOC Required Reading

In addition to the requirements listed on the front page of the Student Packet Submission, Kaiser Permanente Orange County requires the following:

Infection Control – Student Module

Read and Sign

I hereby affirm that I have read and completed all KP Orange County Required Readings. Any such misrepresentation, misstatement, or omission, whether intentional or otherwise, may result in immediate suspension or termination of program participation.

_____ _____

Signature Date