PERMANENTE MEDICINE®

Washington Permanente Medical Group

Clinical Training Agreement

SECTION I: to be completed by trainee (please type or print clearly)

Name: ____

Last | First | Middle Initial | Social Security #

WA License# If other: Specify State & License # | NPI# | DEA# | Discpline (MD,DO etc.)

Date of Birth

☐ Female ☐ Male ☐ Other

He/Him/His | She/Her/Hers | They/Them/Theirs

Preferred Pronouns

Email | ( ) Permanent Telephone | ( ) Cell Phone/Pager

Permanent Address: ____

Street | City | Zip Code | Country

Local Address: ____

Street | City | Zip Code | Country

Current Medical Training Institution | Year in Curriculum | Date Training Began | Anticipated Completion Date

Last Completed School, Degree and Year

Training Type: ☐ Resident ☐ Medical Student ☐ PA/NP Student ☐ Midwifery Student ☐ Fellow ☐ Other: ____________

Specialty Area: ☐ Fam Med ☐ OB/GYN ☐ Pediatric ☐ Surgery ☐ Urgent Care/ Emergency ☐ Other:____________

Preceptor ____________________ ____________________ Kaiser Location ____________

(Clinician's Name – Rotating with, and Specialty)

Training Period (Mo/Day/Yr – Mo/Day/Year) ____________ Estimated Hours per week:____________

At the time requested, I will have completed training in the following areas: ____________

____

Areas of medical interests (include specialties): ____________

Three Learning Goals:

1. ____
2. ____
3. ____

Application for Clinical Training

Note: Your social security number is needed to authorize you access to Kaiser Permanente Health Plan of Washington Intranet Resources and will not be shared outside of the Information Security Department

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Your signature on this letter below indicates that you have read, understood, and agreed to comply with all the above requirements of the Agreement. A signed letter with all other required documentation must be on file with Kaiser Foundation Health Plan of Washington/Washington Permanente Medical Group prior to the start date of your clinical placement. If you have any questions regarding this Agreement, please feel free to email Graduate Medical Education at: graduatemedicaleduca@kp.org.

I have read the Agreement above and understand and agree to all the requirements stated.

____

Signature of trainee   Date

____

Printed name of trainee

RETURN TO:

Graduate Medical Education
Washington Permanente Medical Group
Via Email: graduatemedicaleduca@kp.org

Kaiser Permanente Health Plan of Washington
125 16th Ave East - CHS –545 Seattle, WA 98112
Fax: 206-326-3543

Confidentiality and Security Agreement

Kaiser Permanente – Washington Region

This Agreement applies to all users of Kaiser Permanente information systems. "Kaiser Permanente" means Kaiser Foundation Hospitals, Kaiser Foundation Health Plan, Inc., Kaiser Foundation Health Plan of Washington, Kaiser Permanente Insurance Company, The Permanente Federation, the Permanente Medical Groups, and the subsidiaries, partners and successors of the foregoing. I understand that as a user of Kaiser Permanente information systems, I may have access to non-public, confidential information related to the operations of Kaiser Permanente and I acknowledge my legal and ethical obligations to protect the confidentiality of all such information. Kaiser Permanente's confidential information includes, but is not limited to, the following:

- Patient/member/enrollee/participant health care and financial information, including but not limited to, medical records, credit card and banking information, health plan information, billing and accounts information, claims data, and peer review activities;
- Private employee, personnel, compensation, financial, and health care information;
- Business information relating to Kaiser Permanente and its affiliates and subsidiaries, including but not limited to fiscal, proprietary, research, sales and marketing, planning, risk management, legal, health plan, management information, software and trade secrets.

The above will be referred to as "Kaiser Permanente Information" throughout this Agreement.

By signing below, I acknowledge that I have read and understand this Agreement and hereby agree to comply with its terms. I acknowledge this Agreement is legally binding and that compliance with its terms is a condition of my employment or service contract with Kaiser Foundation Health Plan of Washington, Kaiser Foundation Health Plan of Washington Options, Inc. or Washington Permanente Medical Group and my obligations set forth in this Agreement continue after the termination of such employment or service contract.

Signature: ______________________ Date: ______________________

Name: ______________________ Employee ID: N/A User ID: N/A

Department: N/A Manager: N/A

POLICIES AND INCIDENT REPORTING

I will comply with all Kaiser Permanente privacy, confidentiality, and security policies and procedures. If I have questions about these policies or my obligations, I will consult with my manager or the Privacy Office.

I will complete all required privacy, confidentiality and security training within the required timeframes.

I will immediately notify my manager and the Privacy Office of any actual or suspected privacy, confidentiality or security policy violations, whether intentional or accidental, including, without limitation, compromised passwords and inappropriate use, access or disclosure of Kaiser Permanente Information.

I will cooperate with privacy and security incident investigations.

OWNERSHIP OF INFORMATION

I agree that the Kaiser Permanente Information I access during the course of my employment or relationship with Kaiser Permanente is owned by and belongs to, or is used under license by, Kaiser Permanente. This includes information that I receive, create, transmit, or store on or through Kaiser Permanente information systems or that is maintained for Kaiser Permanente by third parties.

I agree that I do not have any expectation of privacy with respect to my use of Kaiser Permanente Information and Kaiser Permanente information systems. I understand that at any time, with or without notice, Kaiser Permanente may audit, investigate, monitor, access, and disclose information related to my use of Kaiser Permanente Information and/or its information systems, network and Internet access.

I agree that Kaiser Permanente has the right to access, copy, and make unlimited use of any data which I receive, create, store or transmit, regardless of where such data is stored. I further agree to provide Kaiser Permanente access to any such data stored on media in my personal possession, whether or not the storage media is owned by Kaiser Permanente.

AUTHORIZATION TO ACCESS, CREATE, USE, AND DISCLOSE INFORMATION

I understand that my access to Kaiser Permanente information systems is granted by Kaiser Permanente in order for me to perform my job/contractual duties. I will access, create, use, or disclose Kaiser Permanente Information only if there is a legitimate business reason for such access, creation, use or disclosure, and I will limit the information accessed, created, used, or disclosed to the minimum amount necessary to accomplish my duties. I will differentiate my role as a business user of Kaiser Permanente information systems from my personal use as a Kaiser Permanente patient, member or employee by complying with the following:

- I will follow Kaiser Permanente's established processes for accessing information as a Kaiser Permanente member, patient or employee; e.g., through the use of the Kaiser Permanente Member website or official release of information procedures, or as an employee through employee self-service portal, and will not use my business access for personal purposes.
- I will not use my job-related access to Kaiser Permanente information systems to view information about my family members, friends, co-workers, or others for personal purposes. I understand that if I access my own or a family member's health information for personal purposes through any means other than Kaiser Permanente's established processes for patient or member access to such information, my employment or contractual relationship with Kaiser Permanente may be terminated.
- I will use secure messaging on the Kaiser Permanente Member website (and not staff messaging) when communicating as a patient with my Kaiser Permanente provider.

If I use Health Information Exchange functionality, I will only use it for treatment purposes. Health Information Exchange functionality means Kaiser Permanente health information system functionality or connectivity that enables the transmission of health information among organizations including, without limitation, Epic Care Everywhere, Epic Care Elsewhere, Epic Galaxy Wide Net, OneHealthPort HIE, eHealth Exchange, and SureScripts.

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CONFIDENTIALITY

In the course of my work I may see or hear confidential information about Kaiser Permanente patients and members, or about Kaiser Permanente business. I recognize my legal and ethical obligations to protect the confidentiality of all Kaiser Permanente Information. I will not disclose Kaiser Permanente Information to unauthorized individuals. This includes discussing information in public areas and on the internet or in social media in a manner that unauthorized individuals may hear or see.

SECURITY

I will secure Kaiser Permanente Information against loss or misuse, and unauthorized access, disclosure, modification, or destruction by complying with the following:

- I will comply with and not attempt to circumvent security configurations or security policies or standards in any Kaiser Permanente information system.
- I will not share or expose my password or allow others to use my user ID or passwords. I will only use my assigned user ID and password to access Kaiser Permanente Information and information systems that I am specifically authorized to access.
- If I use a portable electronic device, such as an iPhone, laptop, or tablet, to access Kaiser Permanente Information, I will do so in accordance with Kaiser Permanente security policies and standards. I agree to implement appropriate measures to secure the portable electronic device to prevent unauthorized access to or disclosure of Kaiser Permanente Information including, password protection and, as appropriate, encryption.
- If I choose to synchronize my Personally Owned Device to Kaiser Permanente systems, I will read and acknowledge the terms and conditions under the *"Kaiser Permanente Email/Calendar Synchronization for Personally-Owned Devices Program Participant Agreement."*
- I will comply with Kaiser Permanente policy and standards when transmitting confidential information over fax, e-mail, secure messaging, staff messaging, or secure file transfer.
- I will print information from Kaiser Permanente information systems only when necessary for a legitimate business purpose. I acknowledge that I am accountable for the physical security of all information I print.
- I will not copy, move, or store Kaiser Permanente Information to non-Kaiser Permanente systems or removable storage media (flash drives, portable hard drives, etc.) without prior documented approval from the Kaiser Permanente Technology Risk Organization.
- If I have a legitimate business purpose to take any Kaiser Permanente Information off Kaiser Permanente premises, I will only do so with permission from my manager. I acknowledge my duty to protect such data from loss or unauthorized disclosure.
- I will follow Kaiser Permanente policy and standards regarding confidential waste, as well as departmental policies and procedures for disposing of confidential information.
- I will not ask any other person to access Kaiser Permanente Information on my behalf that I am not permitted to access on my own and will, likewise, not access Kaiser Permanente Information for others that they are not permitted to access on their own, except in accordance with established processes for accessing information as a Kaiser Permanente member, patient or employee.

INTELLECTUAL PROPERTY

I agree and acknowledge that all work product including, but not limited to, concepts, works, inventions, information, drawings, designs, programs, code or software developed by me, whether alone or with others, and whether completed or in-progress, created at any time, including prior to the date hereof, in connection with my employment with Kaiser Permanente (collectively, "Work Product") shall be the exclusive property of Kaiser Permanente. Kaiser Permanente owns and will own all right, title and interest (including, but not limited to, all marks, trade secrets, copyrights, patents, and other intellectual property rights) (collectively, "Proprietary Rights") in such Work Product. I agree that the Work Product is and shall be a "work made for hire" to the fullest extent permitted by law, with all copyrights in the Work Product owned by Kaiser Permanente.

To the extent that the Work Product does not qualify as a work made for hire under applicable law, and to the extent that the Work Product includes material subject to copyright, patent, trade secret, or any Proprietary Rights protection, I hereby irrevocably transfer, assign, and convey to Kaiser Permanente all right, title and interest in and to the Work Product, including, but not limited to, all Proprietary Rights in and to any inventions and designs embodied in the Work Product or developed in the course of my creation of the Work Product. This transfer, assignment and conveyance of rights shall include, without limitation, the following: all rights to reproduce said Work Product in copies, to prepare derivative works, and to distribute copies to the public by sale and other transfer of ownership to the full end of the term for which copyrights are granted, and free and clear of any liens, claims or other encumbrances. I agree to execute at any time all such papers and documents as may be advisable, in Kaiser Permanente's opinion, in order to protect, assign, record, renew, or otherwise effectuate the rights herein. I appoint Kaiser Permanente as my attorney-in-fact to execute assignments of, and register all rights to, the Work Product and the Proprietary Rights in Work Product. This appointment is coupled with an interest. I waive, for me, my heirs, successors and assigns, my right to terminate this assignment at any time during the term of the copyright. I acknowledge that I hold no copyright in the Work Product and will have no right to reproduce, prepare derivative works, or distribute copies of the Work Product.

This agreement regarding the assignment of my rights to certain intellectual property does not apply to any invention for which no equipment, supplies, facility, or trade secret information of Kaiser Permanente was used and that was developed entirely on my own time, unless (a) the invention relates (i) directly to the business of Kaiser Permanente, or (ii) to Kaiser Permanente's actual or demonstrably anticipated research or development, or (b) the invention results from any work performed by me for Kaiser Permanente. To the extent the terms of this "Intellectual Property" section conflict with the terms of another agreement governing Kaiser Permanente's ownership of Work Product and Kaiser Permanente's Proprietary Rights therein, the terms of the other agreement shall control.

DISCLOSURE OF TRADE SECRETS

Under the federal Defend Trade Secrets Act of 2016, an individual cannot be held criminally or civilly liable under any federal or state trade secret law for the disclosure of a trade secret that: (1) is made (a) in confidence to a federal, state or local government official, either directly or indirectly, or to an attorney; and (b) solely for the purpose of reporting or investigating a suspected violation of law; or (2) is made in a complaint or other document filed in a lawsuit or other proceeding, if such filing is made under seal.

VIOLATION OF AGREEMENT

I understand that my failure to comply with any part of this Agreement may result in disciplinary or other action, including denial of access to Kaiser Permanente Information, and/or termination of my employment, contract or affiliation with Kaiser Permanente, Kaiser Foundation Health Plan of Washington Options, Inc., or Washington Permanente Medical Group, or my right to practice in Kaiser Permanente medical offices and buildings. I understand that, in some circumstances, Kaiser Permanente may report violations of this agreement to the appropriate regulatory agency or other federal, state or local law enforcement authorities.

KAISER PERMANENTE®

STUDENT AND VOLUNTEER ATTESTATION FORM

NAME: Please print (Use your complete legal name as it appears on your paycheck) **LAST NAME:** ______________________ **FIRST NAME:** ______________________ **MIDDLE INITIAL:** __	**WORK PHONE NUMBER: (Tieline and outside)** **Tieline:** ______________________ **Outside:** ______________________
KAISER PERMANENTE MANAGER'S NAME: (Please print) **LAST NAME:** ________________ **FIRST NAME:** ________________ **MANAGER'S WORK PHONE NUMBER:** ________________	**LOCATION/FACILITY NAME:** **DEPARTMENT:**

I have received copies of the documents listed below:

- Kaiser Permanente *Principles of Responsibility*
- Guide to the Principles of Responsibility
- Five Compliance Expectations
- HIPAA 101: Privacy and Security Basics
- Preventing Fraud, Waste, and Abuse

  - I understand that the requirements in these documents apply to me.
  - I have read, understood, and familiarized myself with these documents.
  - If I have any questions about any of these documents, I will seek clarification from my contact at Kaiser Permanente.
  - I understand that I am expected to conduct myself in an ethical and responsible manner at all times, in accordance with these documents.
  - I agree to abide by the content of these documents and acknowledge that the failure to comply with them can result in my no longer being able to work on assignments for Kaiser Permanente.
  - 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.

By my signature below, I acknowledge, understand, accept, and agree to comply with these requirements. I also understand that failure to comply with these requirements may result in disciplinary action up to and including termination of assignments at Kaiser Permanente and ineligibility for future assignments.

____

Signature ***Date Completed***

KAISER PERMANENTE

School Year:

STUDENT ATTESTATION

Student Name (Last, First, MI): | *Date of Birth:* | *Student Contact Number:*

College/School/University Name: | *Program:*

Address: | *City:* | *Zip code:*

Program Point of Contact: | *Phone Number:* | *Email:*

Kaiser Foundation Health Plan of Washington (KPWA) requires Student and Program/School check and sign below confirming the completion of the following mandatory requirements for students to participate in clinical rotations. All students complete 1-3 below. MD, PA, ARNP, RN, LPN, MA, NA-C etc. students complete 1-4 below. Laboratory students complete 1-5 below.

☐ **1. Tuberculosis (TB) Screening within 12 months prior to commencement of clinical rotation**

- Documentation of a negative TB test
  1. Interferon Gamma Release Assay (e.g., QuantiFERON TB Gold or T-Spot)
  2. Mantoux Two-Step Tuberculin Skin Test (TST)-unless previous positive
- History of a positive TB test, should provide related testing, x-rays and/or treatment documentation
  1. Positive TB test -skin or blood reading or result
  2. Chest X-ray report related to positive TB screening
     - Dated anytime since positive TB test
  3. Treatment documentation, if treated.
  4. Negative symptom screening

☐ **2. Influenza vaccination -** mandatory for students in clinical rotation at any KPWA locations from October 1st thru April 30th

- Documentation for current season

☐ **3. Documentation of Immunity provided to Student's Learning Institution (all students):**

- Positive Measles, Mumps, Rubella titers (lab reports) ***or*** MMR vaccinations (2 dose series)
- Varicella vaccinations (2 dose series) ***or*** positive Varicella titer
- Tdap vaccination (1 dose)

ADDITIONAL IMMUNITY REQUIREMENTS BASED ON PROFESSIONAL ROLE:

☐ **4. MD, PA, ARNP, RN, LPN, MA, NA-C, Radiology etc.**

- Hepatitis B vaccinations (2 dose HEPLISAV-B or 3 dose series completion dates) ***and*** positive Hepatitis B titer (with quantitative value)

☐ **5. LABORATORY (Lab and Microbiology Lab students)**

- Hepatitis B vaccinations (2 dose HEPLISAV-B or 3 dose series completion dates) ***and*** positive Hepatitis B titer (with quantitative value)
- Meningococcal Quadrivalent (A, C, Y, W-135) - (1) dose every five years (**Microbiology ONLY**)
- Serogroup B Meningococcal (Bexsero ***or*** Trumenba)
  - Bexsero - (2) doses
  - Trumenba - (3) doses

Note: Students must complete a series of Hepatitis B vaccines AND have a positive (≥10 mIU/mL) serological quantitative Hepatitis B surface antibody titer (anti-HBs or HBsAb) that was performed at least 1-2 months after the last dose of Hepatitis B vaccine. A positive quantitative titer will not be accepted without documentation of the vaccine series completion or Hepatitis B vaccination declination.

I CERTIFY THAT I HAVE VALIDATED THE IMMUNITY REQUIREMENTS REFERENCED ABOVE FOR THE STUDENT INDICATED ON THIS DOCUMENT AND WILL PROVIDE KPWA IMMUNITY RECORDS UPON REQUEST.

*Student Signature:*____ *Date:* ______________________________

*Verified by:*____ *Date:* ______________________________

Faculty/ Instructor Signature/ Title