General Orientation Packet

Name: 
Department: 
Date: 

Completed Documents
(must be submitted to Human Resources)

There is a $5.00 charge to replace a lost single badge
There is a $10.00 charge to replace a lost double badge
IF YOU ARE UNDER 18 YOU MUST HAVE A PARENT OR GUARDIAN PRESENT WITH YOU TO COMPLETE THIS FORM.

DAVIS REGIONAL MEDICAL CENTER
218 Old Mocksville Rd
Statesville, NC 28625

I, ____________________________ hereby agree to allow
_____________________________ who is under 18 and is my
_____________________________ (relationship), to participate in the Shadowing Program at Davis Regional Medical Center. I am his/her parent/legal guardian and agree to accept responsibility for his/her actions during the time of his/her time at Davis Regional Medical Center.

Signature: ____________________________

Date: ____________________________

Attach copy of Drivers License if applicable
Please complete the attachments and return them to Human Resources.
Please contact Human Resources @ 704-838-7110 if you have any questions or need assistance.

Personal Information/Emergency Contact Form

Please provide the following information. Please print legibly

Name: ____________________________

Home Address: _______________________

Phone #: ___________________________

Company Represented: _______________________

Position/Title: ___________________________

Company Phone #: _______________________

SS#: __________________________ (this is so additional checks may be done in HR)

In the event of an emergency, please list the person(s) that you wish to be contacted.

Please print name of emergency contact ______________________ Phone Number ______________________

Please print name of emergency contact ______________________ Phone Number ______________________

Signature __________________________ date ______________________

Call Davis Regional Medical Center Human Resources at 704-838-7110 with any questions.
# Key Elements - General Orientation

To be completed prior to first day on assignment at Davis Regional Medical Center

<table>
<thead>
<tr>
<th>Topics</th>
<th>Initial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mission / Vision / Values</td>
<td></td>
</tr>
<tr>
<td>Right to Know / MSDS</td>
<td></td>
</tr>
<tr>
<td>Standard Precautions / Bloodborne Pathogens / Infection Control</td>
<td></td>
</tr>
<tr>
<td>Body Mechanics</td>
<td></td>
</tr>
<tr>
<td>Fire Safety</td>
<td></td>
</tr>
<tr>
<td>Electrical Safety</td>
<td></td>
</tr>
<tr>
<td>Hospital Codes</td>
<td></td>
</tr>
<tr>
<td>How to Report an Emergency</td>
<td></td>
</tr>
<tr>
<td>Tuberculosis</td>
<td></td>
</tr>
<tr>
<td>Radiation Safety</td>
<td></td>
</tr>
<tr>
<td>General Safety</td>
<td></td>
</tr>
<tr>
<td>Signs of Impairment</td>
<td></td>
</tr>
<tr>
<td>Workplace Violence</td>
<td></td>
</tr>
<tr>
<td>Abuse/Neglect</td>
<td></td>
</tr>
<tr>
<td>Cultural Diversity</td>
<td></td>
</tr>
<tr>
<td>Prevention of Infant/Child Abduction</td>
<td></td>
</tr>
<tr>
<td>Patient Safety</td>
<td></td>
</tr>
<tr>
<td>Performance Improvement</td>
<td></td>
</tr>
<tr>
<td>HIPAA / Confidentiality/Compliance</td>
<td></td>
</tr>
<tr>
<td>Proper Identification</td>
<td></td>
</tr>
<tr>
<td>License, Registration, and/or Certification(s)</td>
<td></td>
</tr>
<tr>
<td>Patient Rights / Responsibilities</td>
<td></td>
</tr>
<tr>
<td>Risk Management</td>
<td></td>
</tr>
<tr>
<td>National Patient Safety Goals</td>
<td></td>
</tr>
</tbody>
</table>

I have received information on all the preceding items listed, and have a good understanding of all items. I have asked questions regarding those items I do not completely understand.

Signature ___________________________ Department _______________ Date __________

---

I have received information on all the preceding items listed, and have a good understanding of all items. I have asked questions regarding those items I do not completely understand.

Signature ___________________________ Department _______________ Date __________
DAVIS REGIONAL MEDICAL CENTER
INFORMATION SECURITY AGREEMENT

Computerized information systems are one of the Company's most valuable assets. Our success and the privacy of our patients depend on the protection of this information against theft, destruction, or disclosure to outside interests.

You may be required to operate computer equipment or have access to software systems as part of their performance or duties for Hospital Management Association. Those charged with this responsibility must understand information security policies in effect throughout the Company.

Therefore, I agree to the following provisions:

- Not to operate or attempt to operate computer equipment without specific authorization from supervisors.
- Not to demonstrate the operation of computer equipment to anyone without specific authorization.
- To maintain assigned passwords that allows access to computer systems and equipment in strictest confidence and not disclose a password with anyone, at any time, for any reason.
- To access only computer systems, equipment, and functions as required for the performance of my responsibilities.
- To contact my Supervisor or Security Coordinator/Designee immediately and request a new password(s) if mine is (are) accidentally revealed.
- Not to record passwords in any manner, as this increases the possibility of accidental disclosure.
- Not to disclose any portion of the company's computerized system with any unauthorized individuals. This includes, but is not limited to, the design, programming techniques, flow charts, source code, screens, and documentation created by Company employees or outside sources.
- Not to disclose any portion of a patient's record except to a recipient designated by the patient or to a recipient authorized by the Company who has a need-to-know in order to provide for the continuing care of the patient or to discharge one's employment or other service obligation to the Company.
- To report activity that is contrary to the provisions of this agreement to my Supervisor or Security Coordinator.

I understand that failure to comply with the above policies could result in your assignment ending ... for associates employed by DRMC ... this could result in disciplinary action up to and including termination.

Signature:__________________________________________

Date:________________________
Health Management Associates, Inc.

NONDISCLOSURE AGREEMENT

The undersigned recognizes and acknowledges:

That the services the hospital performs for its patients are confidential and that to enable the hospital to perform those services, its patients furnish to the hospital confidential information concerning their affairs; that the good will of the hospital depends, among other things, upon its keeping such services and information confidential; and that by reason of the assignment, you may come into possession of patient information or information concerning the services performed by the hospital for its patients, even though you may not take any direct part in or furnish the services performed for those patients.

You accordingly agrees that, except as directed by the hospital, you will not at any time during or after your assignment by the hospital disclose any of such services or information to any person whatsoever, or permit any person whatsoever to examine or make copies of any reports or other documents prepared by the you, or coming into your possession under you control, that have in any way to do with the patients of the hospital. You recognize that the disclosure of information by you may give rise to irreparable injury to the hospital or to the owner of such information, and that, accordingly, the hospital or the owner of such information may seek any legal remedies against the you which may be available. Disclosure of information by you will result in cause for immediate termination.

You further agrees that you will at all times comply with all hospital and Health Management Associates, Inc. policies and security regulations in effect from time to time for all materials belonging or relating to the hospital or Health Management Associates, Inc.

I have read all of this Agreement, I understand it, and agree to abide by its terms.

AGREED TO AND ACCEPTED ON _______________________

BY: ____________________________________________

(Sign and print name)
DAVIS REGIONAL MEDICAL CENTER
PRIVACY (HIPAA) TRAINING ACKNOWLEDGEMENT

I have read the contents of this packet regarding our organization’s privacy policies and procedures and understand this packet serves as my training. I am aware that any violation of patient privacy or confidentiality should be reported to our Privacy Officer, our Compliance Officer, or the Corporate HIPAA Compliance Manager. I am aware that failure to maintain patient privacy and confidentiality may result in termination of my employment.

Signature:__________________________________________________________

Print Name:________________________________________________________

Department:_______________________________________________________

Date:______________________________________________________________
COMPLIANCE PROGRAM
AWARENESS ACKNOWLEDGEMENT

Our Compliance Officer is our Chief Financial Officer. He can be reached at 704-838-7103 regarding compliance issues.

This Packet of information serves to confirm your awareness of the basic Compliance information at Davis Regional Medical Center.

I am aware that I am to report any violations or suspected violations to my Director, a Compliance Officer, or to HMA on the established Helpline or through the Compliance post office box.

I am aware that this does not represent any type of assignment agreement or contract and my assignment is on an “at-will” basis.

Helpline Telephone Number
1-888-HMA-0380
or
1-888-462-0380

Health Management Associates, Inc.
P. O. Box 770621
Naples, Florida 34107

__________________________________________
Name (Print)

__________________________________________
Signature

__________________________________________
Date