



Date: _____

First Name: _____ Initial: _____ Last Name: _____

Birthdate: _____ Your age as of today: _____

Street: _____

City: _____ State: _____ Zip: _____

Your Phone: _____ Your Email Address: _____

Emergency Contact Name: _____

Emergency Contact Phone Number(s): _____

Vaccination Status: TB Skin Test or Quantiferion Gold within the last 12 months. Proof required with your application.

Name of High School: _____

What nursing areas interest you?

- Surgery (Cath Lab, Endo, OR) Critical Care Medical/Surgical Unknown
 Mother Baby/Labor & Delivery Other: _____

My signature below indicates my agreement to the following:

- I will be on time and participate fully in the job shadowing experience.
- I will be responsible for my own transportation to/from Nursing Boot Camp Immersion Experience.
- I will abide by all of the policies, rules and standards of UK King's Daughters while participating in Nursing Boot Camp Immersion Experience.
- I understand I may be dismissed from the experience at any time if my behavior is inappropriate, unsafe, or disruptive.
- I agree to complete HIPAA Privacy Training at the Nursing Boot Camp event. I further agree to keep confidential any information that I may gain regarding any patient or patients with whom I come in contact during my Nursing Boot Camp Immersion Experience.
- I understand that I may be exposed to sick people during the experience. I agree to comply with any and all instruction provided to me to protect my health, including, but not limited to, personal protective equipment, masking, and handwashing.

Student's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

(Required for applicants under age 18)



Parent/Guardian Consent for Participation

A completed parent/guardian consent form is required for any applicant under the age of 18.

Student's Name: _____ Date of Birth: _____

Parent/Guardian's Name: _____ Daytime Phone: _____

By signing below, I confirm and/or agree to the following:

- I am the parent or legal guardian of the above named student, who is under the age of 18.
- In signing this document, I am agreeing to allow the above named student to participate in the Nursing Boot Camp Immersion Experience sponsored by UK King's Daughters.
- I have reviewed and understand the requirements for participation in the program.
- I have discussed the requirements of the program with the student and will, to the best of my ability, ensure that the student fulfills the obligations as outlined.
- I understand that I am responsible for the student's transportation to and from the Nursing Boot Camp Immersion Experience.
- I understand that the student may be dismissed from the experience at any time if their behavior is inappropriate, unsafe or otherwise does not meet the standards set by UK King's Daughters.
- The student and I have discussed the importance of maintaining the confidentiality of any patient information the student may come to know as a result of the Nursing Boot Camp Immersion Experience.
- I understand that the student may be exposed to sick people during the experience. To the best of my ability, I will ensure that the student complies with any and all instruction provided to them designed to protect their health, including, but not limited to personal protective equipment, masking, and handwashing.

Your signature, below, is consent for the above named minor to participate in UK King's Daughters Nursing Boot Camp Immersion Experience.

Signature of Parent/Legal Guardian: _____ Date: _____

CONSENT TO PHOTOGRAPH/ VIDEO TAPE/INTERVIEW



For use by King's Daughters Marketing/Public Relations Department only

I hereby authorize UK King's Daughters to obtain or permit:

(name of media outlet, agency, publication or other person)

to obtain the following of me while I am under the care of King's Daughters Medical Center
(please check all appropriate descriptions):

- Photographs Film and/or video Interview

I agree that the above named may or permit other persons to use the materials produced from this session for the purpose of (please check all appropriate categories prior to signing this release):

- Educational materials
 Print or broadcast media
 Social media
 Research materials/publications
 King's Daughters publications
 Advertising
 other (please specify): _____

If applicable:

- I agree to the above on the condition I will not be identified by name.

By consenting to these procedures, I release King's Daughters, its team members, physicians and volunteers from any and all liability associated with the securing of photographs, videos or interviews.

Name (please print)

Signature

Parent/legal guardian signature (if applicable)

Witness signature

Date

CONFIDENTIALITY AGREEMENT

Federal and state laws and regulations mandate patient confidentiality. All employees, students, vendors, volunteers, and/or others accessing protected health information at King's Daughters Medical Center ("KDMC") are held accountable for maintaining confidentiality on the subject of patient information, including but not limited to patient identity, patient health information, patient testing or imaging results, and financial accounts. Each employee, student, vendor, volunteer, and/or other individual with access to patient information, including those who may incidentally overhear or observe protected health information at KDMC, shall be expected to maintain strict confidentiality concerning patients even after his/her relationship with KDMC ends.

The Health Insurance and Portability Act of 1996 (HIPAA) and the HITECH Act of 2009 address and define the legal security and confidentiality standards for the protection of patient information. Breach of confidentiality is defined as unauthorized use, discussion or release of confidential information regarding patients, their identity, their patient health information and/or their hospital records (including hard copy and/or electronic). This includes unauthorized retrieval of records on the computer, checking labs or other data without a need to do so, taking photos in areas where patient health information (including patient identity) may be observed, and conversations or discussions that may be overheard by unauthorized persons.

Breach of confidentiality is considered a major offense at KDMC. This violation of personal conduct justifies immediate termination of employee/student/vendor/volunteer/other status without regard to the employee's/student's/vendor's/volunteer's/other's length of service or prior record or conduct.

I, _____, agree that I will not breach patient confidentiality with regard to anything I hear or observe during my visit(s) to KDMC. I understand that I may not utilize KDMC's electronic records to access anyone's records, including my own. I further understand that cell phone use is strictly prohibited during my visit(s) to KDMC to ensure that patient confidentiality is maintained and agree that I will not utilize a cell phone during my visit(s).

By signing below, I certify that I understand the importance of maintaining patient confidentiality and that I agree to abide by the privacy policies and procedures adopted by KDMC. I further certify that I have received training on HIPAA's privacy rules. I understand I may be subject to immediate termination for breach of patient confidentiality if I am an employee of KDMC, or to have my status as a student, vendor, volunteer, or other terminated immediately if I breach confidentiality of KDMC patient information. I further understand that I may be subject to legal action for breach of confidentiality.

Signature of Student

Date

Signature of Parent/Legal Guardian