Our Lady of the Lake Regional Medical Center
House Staff Teaching Program Letter

Name of Resident or Fellow: _____

Institution and Program Specialty: _____

Year in program at time of OLOL rotation: _____

Dates of rotation at OLOL: _____2014-2015 Academic Year_____

I, _____, the undersigned program director, hereby certify the following:

- The above named participant is enrolled and in good standing at _____ _____(Institution/Program).
- The participant has no physical or mental health problems that would interfere with the conduct of medical care as delineated in the written descriptions of the roles, responsibilities, and patient care activities of the participants of medical education programs.
- The participant has fulfilled immunization requirements, documented updated tetanus status, and testing for TB and/or other such infectious diseases as required by federal, state law or regulation, or hospital regulations.
- The participant is covered by professional liability insurance provided by school or program.
- The participant has other insurance to include health insurance, disability insurance, statutory worker's compensation insurance, employer's liability insurance and comprehensive general liability insurance.
- The participant is competent and qualified to perform patient care activities as delineated.
- A representative from the teaching institution has made arrangements for an active member of Our Lady of the Lake's medical staff to serve as a sponsoring physician who has agreed to supervise the participant during his/her tenure at the Hospital.

_____ _____

Signature of Program Director and Date **Signature of Participant and Date**

_____ _____

Name of Program Director (Print) **Name of Participant (Print)**

Institution Address:

_____

_____

_____

Revised: 2/27/2012

OUR LADY OF THE LAKE
REGIONAL MEDICAL CENTER
Franciscan Missionaries of Our Lady Health System

SYSTEMS ACCESS AND CONFIDENTIALITY AGREEMENT

Supplemental Staff/Contracted Services/Medical Staff

Security, data integrity and confidentiality are matters of concern for all persons who have access to Our Lady of the Lake Regional Medical Center (OLOLRMC) information systems. Measures must be taken to ensure that any such computerized systems in use at OLOLRMC and where applicable, OLOLRMC off-site subsidiaries and affiliates can only be accessed by authorized users. As an authorized user of the OLOLRMC information systems, you have a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their health information.

As a condition to receiving access to information, I **(Please print name)** _____ the undersigned, understand and agree to comply with the following items:

1. My User ID and password is the equivalent of my **LEGAL SIGNATURE**. I will not share or disclose my password to anyone nor allow anyone to access any OLOLRMC system or application using my User ID.

2. I am responsible and accountable for all activities undertaken using my User ID/Password.

3. I will not attempt to learn or use another person's User ID or password.

4. I will not access any system or application using a User ID other than my own.

5. I will access confidential information only as needed by me to perform my legitimate duties at OLOLRMC. This means, among other things, that:
   a. I will not access confidential information that I have no legitimate need to know.
   b. I will not in any way divulge, copy, release, sell, loan, revise, alter, or destroy any confidential information except as properly authorized within the scope of my employment.
   c. I will not misuse, carelessly care for or fail to safeguard confidential information.

6. I understand that I have no right or ownership interest in any confidential information referred to in this agreement.

7. It is my responsibility to log out of the system. I will not leave a workstation unattended to which I have logged on.

8. If I have reason to believe that the confidentiality of my User ID has been compromised, I will change my password. I will immediately report any known or suspected breach of the confidentiality of the system or records/data obtained from it to my immediate supervisor.

9. I understand that my User ID will be inactivated upon notification that I am no longer employed, transferred or have no privileges at OLOLRMC when my job duties do not require access to the computerized systems.

10. I understand that the OLOLRMC conducts and maintains an audit trail of accesses to patient information that records the User ID, machine name, date/time, and patient identification.

11. My signature below indicates my understanding of the above noted requirements for the use of any User ID that I am assigned, pursuant to my employment, student, medical staff, or contract responsibilities with OLOLRMC.

12. **I agree to abide by OLOLRMC's policies concerning the use of computers. I understand the computer and all of its accessories are the property of the hospital and are to be used only for hospital business. OLOLRMC reserves the right to examine systems, directories, files and their contents at any time.**

Contract User Signature: _____ Date: _____
Start Date: _____ End Date*:_____
Company Name: _____ Last 4 digits of SSN**_____

OLOLRMC Requestor Signature: _____ Date: _____

OLOLRMC Requestor Name (printed):_____
By signing above you acknowledge that all appropriate paper work has been signed and filed with Human Resources.
**Must be specified, not to exceed 6months ** For identification purposes only.*