SHADOW ATTESTATION

NAME_____

I do hereby state that I am shadowing at Erie County Medical Center Corporation. I agree to abide by all hospital policies and procedures.

I understand that HIPAA regulations regarding privacy and confidentiality require that any and all information concerning a patient, which I may learn while shadowing, including the identity of any patient, may **never** be shared. I further understand that the medical record is a confidential document. I am aware that patient confidentiality must be maintained at all times and I understand that I may be dismissed for any breach of patient confidentiality.

I further understand that I must adhere to all standard precautions and infection control guidelines. I am aware that these guidelines require that I may not under any circumstances enter the room of a patient on isolation precautions, nor transport or otherwise engage in direct contact with such patients. Also, I am not authorized to enter exam rooms, surgical areas, or other areas in which a danger of exposure to blood or body fluids exists. I am not authorized to perform or assist with the performance of medical procedures, to handle blood or body fluids, nor to handle sharps.

I understand that I may be dismissed for failure to adhere to these standards.

NAME (PRINT) _____

SIGNATURE _____

DATE_____

PRECEPTOR NAME (PRINT)_____

SIGNATURE OF PRECEPTOR _____

DATE_____