Student Confidentiality Acknowledgement

I, _____, will be participating as a Student in
(Name of Student)
a clinical/occupational experience in any of the Inova facilities including but not limited to Inova Fairfax Medical Campus, Inova Mount Vernon Hospital, Inova Fair Oaks Hospital, Inova Loudoun Hospital or Inova Alexandria Hospital (individually and collectively, "Hospital") pursuant to an agreement between **Inova Health Care Services ("Inova" or "System") and my School/University, _____ ("Institution")**.
(Name of School/University)

In performing my duties as a Student at the Hospital, I understand that I may encounter, or be provided with, confidential or proprietary information. Therefore, I hereby agree that I will not now or at any time in the future, without the prior written consent of Inova either directly or indirectly divulge, disclose, or communicate in any manner whatsoever to any person not employed or affiliated with the Hospital or the System: (a) any confidential information, including, but not limited to, patient information and information regarding quality assurance, risk management and peer review activities; and (b) any confidential or proprietary information concerning any matters affecting or relating to the business or operations or future plans of the Hospital, the System or any of its affiliates, including, but not limited to, Hospital or System policies, procedures, rules, regulations, and protocols. I understand that this prohibition extends to, but is not limited to, divulging such information for the purpose of acting as an expert witness, reviewer, or consultant on behalf of a plaintiff or an attorney acting on behalf of a plaintiff, in a claim or action against Inova or any of its affiliates. I further agree that in the event I breach this confidentiality requirement, and without limiting the right of the Hospital or the System to seek any other remedy or relief to which it may be entitled under law, I consent to injunctive relief in favor of the System. My acknowledgments and agreements shall survive termination of the Agreement between Institution and Inova.

I certify that I have been trained in the privacy and protection of patient information, as required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and regulations promulgated thereunder. Failure to adhere to the standards in the HIPAA Privacy Rule will result in termination of my clinical/occupational experience and may result in personal liability and assessment of civil and criminal penalties as prescribed in the Rule.

Signature: _____ **Date:** _____

Name: _____

Medication Administration Acknowledgement (Nursing or Allied Health if applicable)

I, _____, will be participating as a Student in
(Name of Student)
a clinical/occupational experience at Inova Fairfax Medical Campus, Inova Mount Vernon Hospital, Inova Fair Oaks Hospital, Inova Loudoun Hospital or Inova Alexandria Hospital (individually and collectively, "Hospital") pursuant to an agreement between Inova Health Care Services ("Inova" or "System") and my college/university/nursing school, _____.
(Name of School/University)

In performing my duties as a Student at the Hospital, I understand that I may administer medications as part of my clinical rotation and assignment requirement for graduation from nursing school. I hereby agree that I will not now

or at any time in the future, administer medications without personal supervision from my instructor or my Registered Nurse senior preceptor.

Signature: _____ **Date:** _____

Name: _____

Witness: _____