Student
Contact Information Sheet/Consent for Release of Information/Clinical Preparatory Contract

Placements for the **Practical Nursing** program are coordinated by Canadore College's School of Health Science.

By signing this document, I _____ ,

1. **authorize Canadore College to share required personal information with our affiliate partner organizations for the sole purpose of arranging academic placements in order to meet the curriculum requirements of the Practical Nursing Program. This may include sensitive personal information including but not limited to: criminal reference backgrounds, immunization records and other pertinent information required by the placement agency.**

2. **agree to submit as instructed the required placement documentation to Synergy Gateway, our evaluation partner. You acknowledge that you will not be eligible to participate in clinical placement if these documents are not submitted by the deadline(s) indicated.**

   This consent will remain in effect until the completion of, or withdrawal from, this program.

Signature:_____ **Date:**_____

Name: _____

Phone Number(s): _____

Email Address: _____

(Please provide email you check most often)

Address while Attending School: _____

Home Address: _____

_____

North Bay Regional Health Centre | Centre régional de santé de North Bay

Confidentiality Agreement

Name: _____
(Please Print)

Affiliation with the Health Centre __STUDENT_____ (for example: Employee, Clinician, Physician, Board Member, Volunteer, Student, Alternative Therapy Clinician, Researcher, Consultant, Vendor, Contractor)

1. During my association with the Health Centre, I may have access to information and material (electronic and manual records) relating to patients, medical staff, employees, or other individuals which is of a private and confidential nature. At all times, I shall respect the privacy of the information I may have access to as well as the privacy of the patients, employees, and all associated individuals whom I may encounter while associated with the Health Centre.

2. I shall treat all the Health Centre administrative, financial, patient, employee and other records as confidential information, and I will protect them to ensure full confidentiality. I shall not read records or discuss, divulge, or disclose such information about the Health Centre, unless there is a legitimate purpose related to my association with the Health Centre. This includes patient information from other facilities I may have access to as part of my regular duties. This obligation does not apply to information in the public domain.

3. I shall ensure that confidential information is not inappropriately accessed, used, or released either directly by me, or by virtue of my signature or security access to premises or systems.

4. I understand that access codes come with legal responsibilities and that I am accountable for all work done under these codes. If I have reason to believe that my access codes or devices have been compromised or stolen, I will immediately contact the appropriate department (i.e. I.S./Security etc.)

5. Violations of this policy include, but are not limited to:
   - accessing information that I do not require for job purposes;
   - misusing, disclosing without proper authorization, or altering patient or personnel information;
   - disclosing to another person my user name and/or password for accessing electronic records;
   - disclosing computer access codes (for example, door codes) that need to be kept confidential and secure;
   - failure to protect physical access devices (for example, keys and badges) and the confidentiality of any information being accessed.

6. I understand that the Health Centre will conduct periodic audits to ensure compliance with this agreement and its privacy policy.

7. I understand and agree to abide by the conditions outlined in this agreement as well as those outlined in the Corporate Privacy Policy, and they will remain in force even if I cease to have an association with the Health Centre.

8. I also understand that should any of these conditions be breached, I will be subject to corrective action up to and including termination of employment, loss of privileges, or termination of a contract or may be fined up to $50,000 as per the current Privacy legislation.

I have read and understand the information contained in the Corporate Privacy Policy

Name (Please Print)	Signature	Date
Name of Witness (Please Print)	Signature	Date

North Bay Regional Health Centre | Centre régional de santé de North Bay

Emergency Contact Form

Name _____ Email _____

Date of Birth ____/____/____ (Day Month Year) Phone Number _____

Address _____ City _____ Postal Code _____

Emergency Contact Information

Name _____ Relationship _____ Phone Number _____

Physician _____ Phone Number _____

Please fill in all areas below

College / University Name: _____

Program: _____ **Department/floor of placement:** _____

Name of Supervisor: _____**Extension:**_____

Dates of placement: _____ **to** _____

CODE OF CONDUCT AGREEMENT

Patient's, residents, clients/outpatients or visitors found to be engaged in violations of the code of conduct may be subject to remedy. Such remedies may include removal of visitation rights or discharge, if appropriate. A patient/client whose judgment is impaired (temporarily or permanently) on account of their mental or cognitive state (e.g. post-operative delirium, dementia, brain injury, psychoses, developmental delay/disability, and autism) may not be responsible for their actions. In such cases appropriate actions(s) will be as per the procedure for patients/clients, outlined in the organization's Workplace Violence and Harassment HS-10

I have reviewed and understand North Bay Regional Health Centre's Code of Conduct and will conduct myself with the standards outlined above.

_____ _____ _____

Print Name Signature Date

Please forward all completed forms to the Education & Achievement Department attention.

Student Support
Human Resources Recruitment Team
Studentsupport@nbrhc.on.ca