Date	AHEC Center	MAHEC ID

MAHEC Pipeline Participant Registration Form

MAHEC is required to report general demographic information about participants. This data will be confidentially maintained and will be referenced periodically to evaluate the effectiveness of AHEC services and programs. We appreciate your cooperation in the completion of this form. Please type or print clearly. Last Revision 5/23

First Name	MI	Last Name
Nickname	Birthdate (mm/dd/yy)	Gender: ☐ Male ☐ Female ☐ Non-Binary/Other

DEMOGRAPHICS

Ethnicity (Select one)
☐ Hispanic
☐ Non-Hispanic

Race (Select all that apply)
☐ African American/Black
☐ American Indian/Alaska Native
☐ Asian
☐ Native Hawaiian/Other Pacific Islander
☐ White

Disadvantaged Status (Select all that apply)
☐ I will be/am the first in my family to go to college
☐ I grew up with English as my second language
☐ I have been diagnosed with a physical or mental impairment that limits my participation
☐ I qualify for the free and reduced school lunch program
☐ I qualify for federal/state grants which do not need to be repaid
☐ Does not apply

Residential Background (Select one)
☐ Frontier (Wide Open, Few People)
☐ Rural (Country, Small Town)
☐ Suburban (Small City)
☐ Urban (Big City)

PARTICIPANT CONTACT INFORMATION

Address		
City	State	Zip Code (9 digits if possible)
Primary Phone # Text okay? ☐ Yes ☐ No	Secondary Phone # Text okay? ☐ Yes ☐ No	
Primary Email Address	Secondary Email Address	

K-12 PARENT/GUARDIAN INFORMATION

Relationship	First Name	Last Name
Address (If different from above)		
City	State	Zip Code (9 digits if possible)
Phone # Text okay? ☐ Yes ☐ No	Email Address	

CURRENT SCHOOL INFORMATION

School Name	Graduation or Anticipated Date of Graduation (mm/yyyy)
City	

SURVEY

I have participated in MAHEC activities in the past and they have increased my knowledge of healthcare careers (leave blank if you have not participated in MAHEC activities in the past or if you are unsure):

☐ Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree

I intend to enter a health career: ☐ Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree

If strongly agree or agree, what <u>three</u> health careers are you interested in? Options are followed by a list of disciplines that fall in each category. Please indicate your top <u>three</u> choices by placing a 1, 2, or 3 in the spaces provided.

____Primary Care Physician
Family Medicine/Family Practice
General Internal Medicine
Obstetrics & Gynecology
General Pediatrics

____Dental
Dentist
Dental Assistant
Dental Hygienist
Endodontist
Oral Surgeon
Orthodontist
Periodontist

____Pharmacy
Pharmacist
Pharmacy Technician

____Physician Assistant

____Behavioral Health
Counselor
Psychologist
Social Worker

____Nursing
Advanced Practice Midwife
Clinical Nurse Specialist
Home Health Aide
Licensed Practical Nurse
Nurse Anesthetist
Nurse Practitioner
Nurse's Aide
Registered Nurse

____Specialty Care Physician
Allergy & Immunology
Anesthesiology
Cardiology
Critical Care/Hospitalist
Dermatology
Emergency Medicine
Endocrinology
Gastroenterology
General Surgery
Geriatrics
Infectious Disease
Neonatology
Nephrology
Neurology
Nuclear Medicine
Oncology
Ophthalmology
Orthopaedic Surgery
Osteopathic Manipulative Medicine
Otorhinolaryngology
Pain Management
Pathology
Physiatry & Rehabilitation
Plastic Surgery
Podiatry
Proctology
Psychiatry
Pulmonology
Radiology
Sports Medicine
Thoracic Surgery (Cardio-Vascular Surgery)
Urology

____Chiropractor

____Health Administration
Healthcare Administrator
Information Technologist
Nursing Home Administrator

____Community & Health Education
Community Health Worker
Health Education
Public Health

____Health Professions
Athletic Trainer
Audiologist
Audiologist-Hearing Aid Fitter
Clinical Lab Technician
Dietitian
EMS/EMT/First Responder
Exercise Science
Hospice Caregiver
Occupational Therapist
Occupational Therapy Assistant
Optometrist
Physical Therapist
Physical Therapy Assistant
Pulmonary Function Technologist
Radiology Technician
Respiratory Therapist
Speech-Language Pathologist

____Other_____

I am interested in a healthcare career, but I worry about (check all that apply):

☐ Cost of education
☐ Whether or not my grades are good enough
☐ Admission exams and the application process
☐ How I would get to and from school (transportation, distance)
☐ How long it would take to complete my education
☐ Where I would work once I did complete my education
☐ What my family and friends would think about me pursuing a healthcare career
☐ Other_____

I intend to work with people who are medically underserved or where there is not enough healthcare:
☐ Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree

I intend to work in the following type of community (select one):
☐ Frontier (Wide Open, Few People) ☐ Rural (Country, Small Town) ☐ Suburban (Small City) ☐ Urban (Big City) ☐ Unsure

I intend to stay in Missouri:
☐ Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree

Are you involved in any other health-related programs such as HOSA, PLTW, Health Occupations? ☐ Yes ☐ No
If Yes, what type of health-related program? ☐ HOSA ☐ PLTW ☐ Health Occupations ☐ Other _____

Are you enrolled in or have you been accepted into a health professions/pre-health professions training program? ☐ Yes ☐ No

☐ CNA ☐ LPN ☐ EMS/EMT ☐ Pre-med ☐ Pre-dental ☐ Medical School ☐ Dental School ☐ Other _____

How did you hear about MAHEC?

☐ MAHEC Website ☐ Facebook ☐ Twitter ☐ At School ☐ From a Friend ☐ Other _____

Thank you!

STUDENT INFORMATION FORM

Name: _____
First **Middle** **Last**

Preferred Name: _____

Street Address: _____

_____ _____ _____
City **State** **Zip Code**

Home Email Address: _____

Home Phone: _____ **Cell Phone**: _____

SSN #: _____ **Birthdate**: _____/_____/_____ **Gender**: **Male** ☐ **Female** ☐

_____ _____
Signature **Date**

HCC Network

Emergency Contact Information

In case of an emergency, please notify:

Emergency Contact #1

Name: _____

Relation: _____

Email Address: _____

Cell Phone: (____) _____

Gender: **Male** ☐ **Female** ☐

Emergency Contact #2

Name: _____

Relation: _____

Email Address: _____

Cell Phone: (____) _____

Gender: **Male** ☐ **Female** ☐

Emergency Contact #3 (Optional)

Name: _____

Relation: _____

Email Address: _____

Cell Phone: (____) _____

Gender: **Male** ☐ **Female** ☐

HCC Network

LEGAL GUARDIAN CONSENT

As the parent/legal guardian of _____, a student at _____, I understand that my child will participate in job shadowing at HCC Network. During this job shadowing experience, my child will receive information and education about healthcare that is provided in a rural community.

HCC Network is not liable for any accidents that happen during the job shadowing experience. Anything that the student sees/hears, that pertains to a specific patient at HCC Network should be kept confidential. This is stated in the handbook and the confidentiality agreement that was provided to the student before the job shadowing experience occurred.

☐ I give my permission to have my child job shadow at HCC Network.

☐ I **DO NOT** give my permission to have my child job shadow at HCC/LWCHC.

Please sign and print your name below to give consent for your child to job shadow at HCC Network.

_____

Legal Guardian/Parent Signature

_____

Legal Guardian/Parent Printed Name

_____

Date

HCC Network

POLICY AND PROCEDURE AGREEMENT

Purpose: The intent of this policy is to alert students who are shadowing the need of discretion at all times and is not intended to inhibit normal business communication.

REQUIREMENTS FOR SHADOWING

Age Requirements: All students who are shadowing must be 16 years of age or older. If said students are younger than 18 years old, they must have a legal guardian sign off on a consent form provided by HCC Network stating that they can shadow at one of our facilities.
Immunizations: All students who are shadowing need to have the following immunizations/tests, before beginning their shadowing. If a student cannot receive one or all of these immunizations or tests, they must provide the appropriate documentation.

- ✓ TB Test
- ✓ Flu Shot
- ✓ Immunization Records

CONFIDENTIALITY AGREEMENT

General: Our clients and other parties with whom we do business entrust HCC Network with personal and private information that may include or pertain to protected health information. It is our policy that all information considered protected and confidential will not be disclosed to external parties or to contractors without a "need to know". If there is a question of whether certain information is considered confidential, the contractor should first check with his/her immediate supervisor.

I hereby acknowledge, by my signature below, that I understand that the Personal Health Information (PHI), other confidential records, and data to which I have knowledge and access in the course of my agreement with HCC Network is to be kept confidential, and this confidentiality is a condition of my agreement. This information shall not be disclosed to anyone under any circumstances, except to the extent necessary to fulfill my educational requirements. I understand that my duty to maintain confidentiality continues even after I am no longer associated with HCC Network.

I am familiar with the guidelines in place at HCC Network pertaining to the use and disclosure of patient PHI or other confidential information. Approval should first be obtained before any disclosure of PHI or other confidential information not addressed in the guidelines, policies and

procedures of HCC Network is made. I also understand that the unauthorized disclosure of patient PHI and other confidential or proprietary information of HCC Network is grounds for disciplinary action, up to and including immediate dismissal.

PHOTO RELEASE STATEMENT

I hereby give my consent for HCC Network to use my photograph and likeness in its publications, including its website and video. I release them from any expectation of confidentiality for the undersigned listed below.

QUALITY COMMITTMENT

I agree that I am committed to ensuring quality patient care and will comply with all quality guidelines and take direction from the quality staff, led by HCC Network Medical Director.

CONFLICT OF INTERTEST STATEMENT

This statement is to be read and signed by all students whom are shadowing. It is prudent to ensure that duality of interest be identified and that any potential conflict of interest, real or perceived, be avoided through established HCC Network procedures.

ALCOHOL AND/OR NON-PRESCRIBED CONTROLLED SUBSTANCE POLICY

The use of alcohol and/or non-prescribed controlled substance is not an acceptable practice while performing HCC Network activities, during normal working hours or at other times when performing said activities.

HCC Network is not responsible for any students who are shadowing who may sustain an injury which is related to or actually caused by the use of alcohol and/or non-prescribed controlled substances while preforming HCC Network duties.

Students who are shadowing will sign this form regarding notice of this policy and it will be retained in said students personnel file.

_____ _____

Signature **Date**

HCC Network

AGREEMENT FOR THE PROVISION OF GRATUITOUS SERVICES

(Please Print Legibly)

_____

First Name Middle Name Last Name

I hereby state that I understand and agree that I am being provided an opportunity to shadow at HCC Network clinics designed primarily for my career exploration benefit, and that I will not be receiving any compensation.

HCC NETWORK

_____ _____

Signature **Date**

Confidentiality Agreement

A Confidentiality Agreement for this purpose is "an agreement under which HCC Network and its potential shadowing student agree on the use, disclosure, limitation/prohibition, and return of information defined as confidential/proprietary. It is used when the HCC Network begins discussions with its potential shadowing student to set forth the terms and conditions related to confidentiality of information shared during their time at HCC Network as well as after the expiration of the designated time at HCC Network."

SCOPE OF CONFIDENTIAL INFORMATION

"Confidential Information" shall mean any and all information disclosed by a Party that is confidential and/or proprietary information relating to the business, financial, and strategic condition of such Party, which may be in written, oral, or electronic format ("Confidential Information"). In addition, the terms, and conditions of any agreements between the Parties shall be considered Confidential Information. The term Confidential Information shall not include information that is or becomes publicly available through no fault of either Party.

PROHIBITION AND LIMITATION OF DISCLOSURE

A. Each Party acknowledges that the Confidential Information furnished by the other Party during the course of the time with HCC Network is a valuable, special, and unique asset of the Party furnishing such Confidential Information (hereinafter, the "Furnishing Party"). Accordingly, each Party agrees that, except as specifically provided herein, it will not disclose to any person, institution, entity, company, or any other third party, directly or indirectly, any Confidential Information, without the prior written consent of the Furnishing Party.
B. Each Party agrees that it will use best efforts to keep confidential the Confidential Information received from the other Party. Further, each Party agrees that Confidential Information shall be disclosed to members of its Board, staff, contractors, or other agents only: (1) on a need-to-know basis, and (2) for the purpose of planning and due diligence review contemplated by this Agreement.

USE OF CONFIDENTIAL INFORMATION

Each Party agrees not to use the Confidential Information of the other Party for its own benefit or for the benefit of any third party.

PERMISSIBILITY OF DISCLOSURE

Nothing in this Agreement shall prohibit a Party from making any disclosure of Confidential Information that, in the good faith opinion of the attorneys for such Party making the disclosure, is required by law. If disclosure of the Confidential Information is required, the Party making the disclosure shall promptly notify the Furnishing Party, and shall exercise reasonable efforts to obtain, or to permit the Furnishing Party to obtain, a court order or other reliable assurance that confidential treatment shall be accorded to the disclosed Confidential Information.

REPRESENTATIONS

Each Party warrants that, to its knowledge as of the Effective Date and at the time of any subsequent disclosure, it is permitted to disclose to the other Party, as provided herein, its respective Confidential Information and that such disclosure does not, and will not, violate the rights of any third party.

RETURN OF CONFIDENTIAL INFORMATION

Each Party shall retain title and all rights to the Confidential Information that it has disclosed to the other Party. Upon request, or upon termination of this Agreement discussions between the Parties, each Party agrees to promptly return to the other Party all Confidential Information furnished by such Party. Each Party further agrees that it will not retain any electronic or paper copies, extracts, or other reproductions, in whole or in part, of such returned Confidential Information.

HCC Network

REMEDIES FOR VIOLATION

The Parties agree that the disclosure of Confidential Information, without the express written consent of the Party that furnished such Confidential Information, will cause such Party irreparable harm. Each Party shall have the right to enjoin the other Party or Parties from any disclosure or threatened disclosure of Confidential Information in violation of this Agreement. The right to injunctive relief shall be in addition to other rights and/or legal remedies which a Party may have against the other Party upon actual or threatened violation of this Agreement.

TERM AND TERMINATION

This Agreement shall become effective on _____ and shall remain in full force until completion of training.

Student Signature: _____ **Date:** _____

Printed Name: _____

Student

MAHEC/AHEC Signature: Stephanie Taylor **Date:** _____

Stephanie Taylor

Director of AHEC

HIPAA Training

Presented by West Central Missouri AHEC

Introduction of HIPAA

- What is HIPAA?_____
- What does HIPAA stand for?_____
- When did it become a law?_____

Four main purposes of HIPAA:

*

*

*

*

Security Rule Safeguards:

*

*

*

What is Privileged communication?

Why was the Privacy Rule established?

Privacy Definitions:

- Protected Health Information (PHI)
- Privacy
- Confidentiality
- Disclosure

What is Authorization?

What are six patient rights?

1.

2.

3.

4.

5.

6.

What responsibilities do the medical facilities have?

What are six rules of disclosure without authorization?

1.

2.

3.

4.

5.

6.

Name some of the items contained in a medical record:

Who has ownership of a medical record?

Name some advantages to having electronic medical records:

Name some disadvantages to having electronic medical record:

What steps can be taken to make sure electronic records are confidential and secure?

When shadowing and volunteering, what is the most important thing to remember when seeing a patient you may know, or even discussing a patient you don't know?

_____

Student Signature

_____

Date