



University Health Network

Toronto General Hospital Toronto Western Hospital Princess Margaret Hospital

University Health Network Nursing Education Department

Agreement form - to be signed by clinical
faculty or students at the beginning of each
clinical placement

Name: _____
(Please Print)

Office Use:
OK to file

Affiliation with UHN: _____

(For example: Clinical Faculty, Nursing Student, etc.)

Name of Educational Institution: _____

Location at UHN: _____

1. Confidentiality Agreement

1. During my association with University Health Network (UHN), I will have access to information and material relating to patients, medical staff, employees, other individuals, or UHN, which is of a private and confidential nature.
2. At all times, I shall respect the privacy and dignity of patients, employees, and all associated individuals.
3. I shall treat all UHN 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 UHN, unless there is a legitimate purpose related to my association with UHN. This obligation does not apply to information in the public domain.
4. 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.
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 your user name and/or password for accessing electronic records.
6. I shall only access, process, and transmit confidential information using hardware, software, and other authorized equipment, as required by the duties of my position.
7. I understand that UHN will conduct periodic audits to ensure compliance with this agreement and its privacy policy.
8. I understand and agree to abide by the conditions outlined in this agreement, and they will remain in force even if I cease to have an association with UHN.
9. I also understand that should any of these conditions be breached, I may be subject to corrective action up to and including termination of employment, loss of privileges, termination of a contract, or similar action appropriate to my association with UHN.

2. I have read and understood **Guidelines for Ethics In Clinical Teaching**.

3. I have reviewed the UHN Infection Control Routine Precautions.

Name (Please Print)

Signature

Date

Name of Witness (Please print)

Signature

For statistical purposes, please provide the first three letters/numerals in your permanent home postal code. We will not use this information to contact you.

_____	_____	_____
Letter	Numeral	Letter