Miami Dade College
Medical Campus

MIAMI DADE COLLEGE
MEDICAL CAMPUS
Student Health Record Form

Name: ____ Student Number: ________________
Last First Middle Initial

I understand that student health information is protected and confidential under State of Florida and federal laws. I voluntarily provide, and consent to my medical provider or physician providing, the medical information contained in this document to the Miami Dade College and health care facilities that I am assigned to as part of Miami Dade College's medical program requirements. I also understand that all requested Student Health Record information is a prerequisite to enrollment in the clinical training of any Medical Center Campus program. Failure to complete this record will prevent my participation in the clinical training. The student and Health Care Examiner (MD, DO, PA, ARNP) must sign in the appropriate spaces provided on the form. **Documentation of all titers, vaccines, drug screening, TB testing, and x-rays must be attached to the student health record.**

SECTION 1: PERSONAL INFORMATION
All areas of this section must be completed. This information will be kept on file and used in the event that the student must be contacted or an emergency contact is required.

SECTION 2: REQUIRED INFLUENZA INJECTION (FLU SHOT)
Students participating in a clinical rotation must receive the influenza injection. Students that cannot participate in the influenza injection process as a result of a medical condition or refuse to participate in the influenza injection may be required to participate in additional measures established by a clinical site. Additionally, it may jeopardize the student's ability to participate in the clinical portion of a Medical Campus program. It is highly recommended that all students receive the influenza injection.

SECTION 3: REQUIRED TITERS/TESTS

A. **Varicella (Chicken Pox):** A Varicella Titer must be drawn and ***the results attached.*** **A record of the Varicella Vaccine will not be accepted as documentation of the required titer.** The date of the titer and results must be indicated in the appropriate area. ***(INDICATING THE DISEASE PROCESS OR IMMUNIZATION DATES IS NOT ACCEPTABLE FOR DOCUMENTATION IN THIS AREA).***

Mumps, Rubeola (Measles), and Rubella (German Measles): A Mumps, Rubeola, and Rubella Titer must be drawn and ***the results attached.*** A **record of the MMR (Mumps, Measles, Rubella) Vaccine will not be accepted as documentation of the required titer.** The dates of the titers and the results must be indicated in the appropriate area***. (INDICATING THE DISEASE PROCESS OR IMMUNIZATION DATES IS NOT ACCEPTABLE FOR DOCUMENTATION IN THIS AREA).***

B. **TB Skin Test:** Two consecutive TB Skin Tests are required. The TB Skin tests can be repeated a minimum of seven days apart. ***The dates and results of each TB Skin Test must be attached.*** The Skin Tests must have been performed within the last three (3) months to be considered a recent test. Results from QuantiFERON are acceptable within the last three (3) months.

Chest X-ray: A recent Chest x-ray is required if a positive TB skin Test or QuantiFERON is reported or there is a history of a positive TB Skin Test. The chest x-ray must have been completed within the last three (3) months to be considered current. ***Results must be attached.***

C. **Drug Screening:** A minimum of a 10-panel drug screen is required. A second drug screen test may be required by some health care facilities. ***A positive result on this test will result in the student's inability to participate in the clinical portion of any Medical Campus program at Miami Dade College.*** **The results must be indicated and attached.**

Section 4: Hepatitis B Vaccine
Students must provide documentation of the initiation or completion of the Hepatitis B vaccine series at the time of application. It is highly recommended that the student complete the series while enrolled in the program. Further information of the Hepatitis B Vaccine is provided on the Student Health Record Form on page 3. **The results must be attached.**

Section 5: Tdap (Tetanus, Diphtheria, Pertussis) Vaccination
Students must provide documentation of the Tdap vaccination within the last ten (10) years.

Section 6: Student's Statement
Student must read and sign this statement on page 3 of the Student Health Record.

Section 7: Examiner's Statement
The Health Care Examiner (MD, DO, PA, and ARNP) must read, sign, and confirm that the student can meet the Physical Demands associated with the program in the Examiner's Statement Area on page 4 of the Student Heath Record.

Please Place Health Care Provider Office Stamp or Attach Business Card Here (Required):

MIAMI DADE COLLEGE
MEDICAL CAMPUS
SCHOOL OF HEALTH SCIENCES
EMERGENCY MEDICAL TECHNICIAN (EMT) PROGRAM APPLICATION

____ _______________________________
Student Name (Print) Student Number

Email address: ____

Class Preference:	
	Medical Campus, Monday & Wednesday: 5:00 PM – 9:00 PM
	Medical Campus, Tuesday & Thursday: 5:00 PM – 9:00 PM
	Homestead Campus, Tuesday & Thursday : 6:00 PM – 10:00 PM
	North Campus: Tuesday &Wednesday 9:00 – 1:00PM Thursday: 8:00 AM – 4:00 PM

APPLICATION REQUIREMENTS:
THE FOLLOWING ITEMS MUST BE INCLUDED WITH THE APPLICATION TO BE ACCEPTED AND/OR REGISTERED FOR THE CLASSES ASSOCIATED WITH THE PARAMEDIC PROGRAM. IT IS THE STUDENT'S RESPONSIBILITY TO PROVIDE ALL COPIES OF REQUIRED INFORMATION, HEALTH DOCUMENTATION, AND CRIMINAL BACKGROUND VERIFICATION.

	REQUIRED ITEMS/INFORMATION
	COPY OF FIRST RESPONDER CERITIFICATE OR EQUIVALENT
	COPY OF CURRENT CPR CERTIFICATION, BLS FOR HEALTH CARE PROVIDERS
	COMPLETED STUDENT HEALTH RECORD FORM (must be included with extra copy of form and lab tests results)
	Documentation of Influenza Shot and Hepatitis B Vaccine Series
	Documentation of a titer results for Varicella, Mumps, Rubella, and Rubeola
	Documentation of a 10 panel drug screen test
	Documentation of TWO (2) TB skin Tests/ or QuantiFERON test [performed within the last three (3) months]
	Documentation of Tdap (Tetanus, Diphteria, Pertussis) Vaccination within the last TEN (10) years
	Signature of the health care examiner
	COPY OF PERSONAL MEDICAL INSURANCE CARD
	COPY OF EMAIL DEMOSTRATING COMPLETION FO THE CRIMINAL BACKGROUND CHECK FROM THE DESIGNATED BACGROUND CHECK PROVIDER. ***Student must submit a copy of the email verification of the criminal background to satisfy this requirement.***
	PROOF OF ACCEPTABLE PERT SCORES OR EQUIVALENT
(STAFF USE ONLY) Date Received: ___________________________ Initials: ______________________	

SECTION 1: PERSONAL INFORMATION

____ Apt.#______ ____________________________ Address
E-mail address

_________________________ ____________ ________________Gender: M ____ F ____
City State Zip Code

_____ / _____ / ______ ____________________ ______________________
Date of Birth Home Telephone Number Cellular Phone Number

_______________________________________ _________________ _______________________
Person to Notify in Emergency Relationship Contact Telephone Number

SECTION 2: INFLUENZA INJECTION (Documentation must be attached)

Date of injection: ____________________

I understand that if I cannot participate in the influenza injection process as a result of a medical condition or refuse to participate in the influenza injection, I may be required to participate in additional measures established by a clinical site. Additionally, it may jeopardize my ability to participate in the clinical portion of a Medical Campus program.

STUDENT SIGNATURE: ____ DATE: ______________

SECTION 3: REQUIRED TITERS/TESTS

Parts A, B, C: THESE BOXES ARE TO BE COMPLETED BY AUTHORIZED MEDICAL PERSONNEL ONLY

A. REQUIRED TITERS: (Documentation must be attached)

A Varicella (Chickenpox), Mumps, Rubeola (Measles), and Rubella (German Measles) Titer must be drawn and the results attached. ***A record of Vaccines WILL NOT BE ACCEPTED as documentation for the required titers.*** The dates of the titers and the results must be indicated in the appropriate area below. ***(INDICATING THE DISEASE PROCESS OR IMMUNIZATION DATES IS NOT ACCEPTABLE FOR DOCUMENTATION IN THIS AREA).***

TITER	DATE	LAB RESULTS (Documentation must be attached) (Numerical Value of Results Must Be Reported Below)	Please Circle
Varicella (Chickenpox) Titer	____/____/____ Month Day Year		**Immune/ Not Immune**
Mumps Titer	____/____/____ Month Day Year		**Immune/ Not Immune**
Rubeola (Measles) Titer	____/____/____ Month Day Year		**Immune/ Not Immune**
Rubella (German Measles) Titer	____/____/____ Month Day Year		**Immune/ Not Immune**

B. TB SKIN TEST/ QUANTIFERON /CHEST X-RAY

Two consecutive TB Skin Tests are required. ***The TB Skin tests can be repeated a minimum of seven days apart***. The dates and results of each TB Skin Test must be attached. The Skin Tests must have been performed ***within the last three (3) months*** to be considered a recent test. Results from QuantiFERON are acceptable. **In the event the results indicate a positive skin test or QuantiFERON, or the student has a history of a positive TB skin test, a chest x-ray is required. The chest x-ray must have been completed within the last three (3) months to be considered current. Results must be attached.**

TEST	DATE	RESULTS	
TB Skin Test **1st Test**	____/____/____ **Month Day Year**	**Positive _____ Negative_____**	**If positive skin test, current chest x-ray is required. *Results of TB skin test must be attached.***
TB Skin Test **2nd Test**	____/____/____ Month Day Year	**Positive _____ Negative_____**	**If positive skin test, current chest x-ray is required. *Results of TB skin test must be attached.***
QuantiFERON	____/____/____ Month Day Year	**Positive _____ Negative_____**	**If positive, current chest x-ray is required. *Results of QuantiFERON must be attached.***

Chest X-ray	____/____/____ Month Day Year	Positive _____ Negative_____	***RESULTS OF CHEST X-RAY MUST BE ATTACHED***

C. DRUG SCREENING

A **minimum** of a 10-panel drug screen is required. *A positive result on this test will result in the student's inability to participate in the clinical portion of any Medical Campus program at Miami Dade College.* The results must be indicated and attached.

TEST	DATE	RESULTS	
Drug Screen **(10 Panel)**	____/____/____ Month Day Year	**Positive _____** **Negative_____**	***A positive result on this test will result in the student's inability to participate in the clinical portion of any Medical Center Campus program at Miami Dade College. RESULTS OF 10 Panel DRUG SCREEN TEST MUST BE ATTACHED.***

SECTION 4: HEPATITIS

Introduction: Health care professionals are at risk of exposure to blood and body fluids contaminated with the viruses that cause HIV and Hepatitis. Consistent use of Standard Precautions is the best known means to avoid transmission of these viruses or other contaminants. Students will be taught Standard Precautions before they provide care to any patient in the clinical setting. Although it is rare, a health care worker may become exposed to one of these viruses through accidental transmission. Currently, there is no vaccine that protects against the HIV virus. However, the Hepatitis B vaccine is an effective means of preventing Hepatitis B. As a student who will be providing direct patient care, you should discuss this vaccine with your health care provider.

About the Vaccine: The Hepatitis B Vaccine is a genetically engineered "yeast" derived vaccine. It is administered in the deltoid muscle (arm) in a series of three doses over a six month period. You should seek additional information about the vaccine from your health care provider; especially if you have an allergy to yeast or may be pregnant, or are a nursing mother.

I have initiated the Hepatitis B Vaccine Series with my first dose listed below: **(ATTACH COPY OF DOCUMENTATION)**

1st Dose: Date: ____/____/____ 2nd Dose: ____/____/____ (One month after 1st dose) 3rd Dose: ____/____/____ (Six months after 1st dose)

OR

I have already completed a Hepatitis B Vaccine Program with dates of injections listed below: **(ATTACH COPY OF DOCUMENTATION)**

1st Dose: Date: ____/____/____ 2nd Dose: ____/____/____ (One month after 1st dose) 3rd Dose: ____/____/____ (Six months after 1st dose)

OR

Antibody testing has revealed that I have immunity to Hepatitis B. Yes _____ No _____
(ATTACH COPY OF LAB REPORT).

SECTION 5: Tdap (Tetanus, Diphtheria, Pertussis) Vaccination

Students must provide documentation of the Tdap vaccination within the last ten (10) years.

Received: ____/____/____ (ATTACH COPY OF DOCUMENTATION)
Month Day Year

SECTION 6: STUDENT'S STATEMENT

In order to satisfy medical program requirements, I hereby consent to the release and disclosure of my personal health information provided on the **Student Health Record Form** to Miami Dade College and any health care facility in which I am assigned for on-site clinical training. I understand that my personal health information is required to facilitate my participation in the clinical training, which is required for program completion. I also hereby release and hold harmless Miami Dade College and receiving health care facilities from any claim of violation of HIPAA or any other medical privacy rights that may arise for the release of my personal health information provided in the **Student Health Record Form**.

Print Name: ____

Student Signature:____ Date:____________________

PHYSICAL DEMANDS

In order to fulfill the requirements of the EMS Program at Miami Dade College, students must be able to meet the physical demands associated with the profession. Examples of these requirements include but are not limited to the following:

Code: F = frequently O = Occasionally NA = Not Applicable

Physical Demands	Code	Comments
Standing		
Walking		
Sitting		
Lifting (up to 125 pounds)		
Carrying		
Pushing		
Pulling		
Balancing		
Climbing		
Crouching		
Crawling		
Stooping		
Kneeling		
Reaching		
Manual Dexterity		
Feeling		
Talking		
Hearing		
Seeing		
Communicating		

(For specific Performance Standards associated with the EMS Program please contact the Program Coordinator at 305-237-4337.

Limitations: ____

____

SECTION 7: EXAMINER'S STATEMENT

I have verified that the individual I have examined is the named individual on this document and that the information about the test results are correct. This individual can participate in all activities required to provide health care to patients in an acute or chronic care facility, emergency setting or any other situation that is part of the learning experiences in the designated health care program. The student is able to meet THE PHYSICAL DEMANDS that are listed above. **(List any limitations associated with this student in the area provided).**

____ _____________________

MD/DO/PA/ARNP Signature Date

____ _____________________

Office Telephone Number License Number

MIAMI DADE COLLEGE
MEDICAL CAMPUS

CRIMINAL HISTORY INFORMATION CHECKS REQUIRED FOR MEDICAL CAMPUS PROGRAM STUDENTS

Florida law requires level 2 criminal background screenings for "all employees in position of trust or responsibility", pursuant to §435.04, Florida Statutes (2004). The Joint Commission of Accreditation of Healthcare Organizations (JCAHO), a healthcare accreditation entity, also requires healthcare facilities to conduct background screenings on employees, students, and volunteers in accordance with state law and regulation and/or the internal procedures of the healthcare facility. The purpose of the level 2 criminal background screenings, which include fingerprinting and a state and federal criminal records check, is to ensure patient safety and maintain trust and integrity within the healthcare professions.

Many of the College's healthcare training facilities now require the College to conduct level 2 criminal background screenings on all faculty, students and any other person who participates in clinical training at a healthcare facility. In response to this requirement, all faculty, students or any other persons that participate in the College's clinical training programs are required to obtain a level 2 criminal background screening <u>before</u> beginning their participation or continuing their participation in any of the College's clinical placement programs. In most instances, previous screenings are not accepted by the College.

To obtain the level 2 background check for your enrollment in your selected program at Miami Dade College, students should do the following:

1) Schedule an appointment at http://ibrinc.com/mdc/select

2) Follow the link identified as "Medical Campus Student".

3) Complete the requested information for the completion of the background check process.

(Rev: 10/2012)

MIAMI DADE COLLEGE
MEDICAL CAMPUS

ACKNOWLEDGMENT AND CONSENT FOR RELEASE OF INFORMATION

I understand that placement in a clinical setting is an essential component of my education in a health science program offered by the Medical Campus of Miami Dade College.

I have been informed that many healthcare agencies require a level 2 criminal background screening as a prerequisite for placement in an agency. I hereby consent to Miami Dade College receiving the results of my level 2 criminal background screening. I also understand that this information will be held confidential by the College and will not become a part of my student record. I give the College permission to disclose and/or share the results of the screening with a clinical agency for the sole purpose of clinical placement eligibility within a clinical agency.

I acknowledge that the clinical agency may make the determination, regarding specific criminal charges, that would disqualify me from participating in a clinical program, and that Miami Dade College is not involved in, and has no control over, that determination. I understand that if I am disqualified from participating in the clinical program as a result of the criminal background screening, I may not be permitted to continue in the Medical Campus program in which I am enrolled.

I hereby sign this form voluntarily with the understanding that a level 2 criminal background check is a prerequisite to clinical placement in a Miami Dade College Medical Campus program.

Name:____

Date of birth:____________________________Student Number: ___________________

Medical Campus Program ______________________________

I have worked, resided or been a student in a state other than Florida, or a country other than the United States, during the past 24 months:

Yes_______No_______.

If yes, name of state or country:

____
Student Signature

Miami-Dade County Fire Rescue
9300 N.W. 41st Street
Miami, FL 33178
786-331-5000

REQUEST FOR PERMISSION TO RIDE AS AN OBSERVER WITH THE MIAMI-DADE FIRE RESCUE DEPARTMENT HOLD-HARMLESS AGREEMENT

The undersigned (PARTICIPANT), being eighteen years of age or older, does hereby request the Miami-Dade Fire Rescue Department of Miami-Dade County, Florida, to allow the aforementioned to observe fire rescue and emergency service procedures, techniques, or practices by an authorized representative of the Miami-Dade Fire Rescue Department at an authorized facility, in a practical field environment, or in an authorized Miami-Dade Fire Rescue Department vehicle. If permission is granted, I hereby agree to obey at all times all instructions, orders and commands given me by the officer or officers in command of the training or instruction exercise. (If under eighteen years of age complete section 2).

I FULLY REALIZE AND APPRECIATE THE BASIC NATURE OF FIRE RESCUE AND EMERGENCY SERVICE WORK AND THE POSSIBILITY THAT SITUATIONS WILL ARISE WHICH MIGHT RESULT IN MY BEING EXPOSED TO DANGER INCLUDING, BUT NOT LIMITED TO, INFECTIOUS DISEASES, MOTOR VEHICLE, AIRCRAFT, OR BOATING ACCIDENTS; ANY INTENTION OR NEGLIGENT ACTS OR OMISSIONS BY ME, OR ANY OFFICER, EMPLOYEE OR AGENT OF MIAMI-DADE COUNTY, OR MALFUNCTION OF EQUIPMENT USED DURING TRAINING OR INSTRUCTION.

THEREFORE, in consideration for the educational benefit to be received and the granting of the above request, I hereby agree to hold Miami-Dade county, its Board of County Commissioners, its employees, agents, and servants harmless from all liability for property damage, physical harm, personal injury, or death arising out of riding and observing rescue services, and I further agree to waive all rights or claims to damages, legal or equitable, arising out of any intentional, unintentional or negligent acts or omissions by me, or any officer, employee, or agent of Miami-Dade County, or a malfunction of any equipment used during observation ride(s).

Appropriate dress code for observers will include dark colored slacks, dark colored flat shoes and a white shirt/blouse or an identifiable uniform, such as military or nurse. Dress attire must be approved by the Officer in charge of the unit.

In order to comply with the **Federal HIPAA (Health Insurance Portability Accountability Act) Law,** Miami-Dade Fire Rescue Department will NOT allow observers to film, take pictures or participate in any other activity that may violate patient confidentiality.

This agreement shall remain in effect for every occasion on which the participant requests and is granted permission to receive training or instruction.

The undersigned acknowledges that this agreement has been read, understood, fully explained, and all question regarding it have been answered.

____
Type Participant's Name

____
Participant's Address

Age: _______ Home Phone Number: ___________________

Other Contact Number: ________________________________

ALS Pre-Hospital Affiliation: Yes No

____
Fire Rescue Department Employee Witness Signature

STATE OF FLORIDA
COUNTY OF MIAMI-DADE

Section 1

I, the undersigned authority, hereby certify that the forgoing instrument is a true and correct copy of the instrument presented to me by ________________________ as the original of such instrument.

WITNESS my hand and official seal, this _____ day of ___________________ AD., 20________________.

Type of Identification: Driver License

Other: _________________________

____
Notary Public State of Florida

____
My Commission Expires:

Section 2

Must be completed by Parents of Youths under 18

I certify that I am the parent or legal guardian of _______________________ who is under eighteen years of age. We have read and understand the REQUEST FOR PERMISSION TO OBSERVE WITH THE MIAMI-DADE FIRE DEPARTMENT AND HOLD HARMLESS AGREEMENT-YOUTH, and we agree to allow our child to participate as an observer and to the terms and conditions set forth therein.

LEGAL GUARDIAN'S NAME: ______________________________

LEGAL GUARDIAN'S SIGNATURE _________________________ DATE: ___________________________

STATE OF FLORIDA
COUNTY OF MIAMI-DADE

Before me personally appeared ______________________________ and _________________________________ to me well known and known to me to be the person described herein and who exacted the foregoing instrument, and acknowledged to and before me that ______________________ executed said instrument for the purposes therein expressed. to me

WITNESS my hand and official seal, this _____ day of ___________________ AD., 20_________________

____
Notary Public State of Florida at Large

My Commission Expires: _________________________

*Applications submitted by mail must be NOTARIZED.

Student Confidentiality – HIPAA Compliance

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of HHS to publicize standards for the electronic exchange, privacy and security of health information. Collectively these are known as the *Administrative Simplification* provisions

The HIPAA Privacy Rule (Rule) provides federal protections for individually identifiable health information held by covered entities and their business associates and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of health information needed for patient care and other important purposes.

The Security Rule specifies a series of administrative, physical, and technical safeguards for covered entities and their business associates to use to assure the confidentiality, integrity, and availability of electronic protected health information.

A major goal of the Rule is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well-being. The Rule strikes a balance that permits important uses of information, while protecting the privacy of people who seek care and healing. Given that the health care marketplace is diverse, the Rule is designed to be flexible and comprehensive to cover the variety of uses and disclosures that need to be addressed.

What Information is Protected

Protected Health Information. The Rule protects all *"individually identifiable health information"* held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information "protected health information (PHI)."[12]

"Individually identifiable health information" is information, including demographic data, that relates to:

- the individual's past, present or future physical or mental health or condition;
- the provision of health care to the individual; or
- the past, present, or future payment for the provision of health care to the individual,and that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual.[13] Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).

The Rule excludes from protected health information employment records that a covered entity maintains in its capacity as an employer and education and certain other records subject to, or defined in, the Family Educational Rights and Privacy Act, 20 U.S.C. §1232g.

Enforcement and Penalties for Noncompliance

Compliance. The Standards for Privacy of Individually Identifiable Health Information (Privacy Rule) establishes a set of national standards for the use and disclosure of an individual's health information – called protected health information – by covered entities, as well as standards for providing individuals with privacy rights to understand and control how their health information is used. The Department of Health and Human Services, Office for Civil Rights (OCR) is responsible for administering and enforcing these standards and may conduct complaint investigations and compliance reviews.

Consistent with the principles for achieving compliance provided in the Rule, OCR will seek the cooperation of covered entities and may provide technical assistance to help them comply voluntarily with the Rule. Covered entities that fail to comply voluntarily with the standards may be subject to civil money penalties. In addition, certain violations of the Rule may be subject to criminal prosecution. These penalty provisions are explained below.

Civil Money Penalties. OCR may impose a penalty on a covered entity for a failure to comply with a requirement of the Privacy Rule. Penalties will vary significantly depending on factors such as the date of the violation, whether the covered entity knew or should have known of the failure to comply, or whether the covered entity's failure to comply was due to willful neglect. Penalties may not exceed a calendar year cap for multiple violations of the same requirement.

	For violations occurring prior to 2/18/2009	**For violations occurring on or after 2/18/2009**
Penalty Amount	Up to $100 per violation	$100 to $50,000 or more per violation
Calendar Year Cap	$25,000	$1,500,000

A penalty will not be imposed for violations in certain circumstances, such as if:

- the failure to comply was not due to willful neglect, and was corrected during a 30-day period after the entity knew or should have known the failure to comply had occurred (unless the period is extended at the discretion of OCR); or
- the Department of Justice has imposed a criminal penalty for the failure to comply (see below).

In addition, OCR may choose to reduce a penalty if the failure to comply was due to reasonable cause and the penalty would be excessive given the nature and extent of the noncompliance.

Before OCR imposes a penalty, it will notify the covered entity and provide the covered entity with an opportunity to provide written evidence of those circumstances that would reduce or bar a penalty. This evidence must be submitted to OCR within 30 days of receipt of the notice. In addition, if OCR states that it intends to impose a penalty, a covered entity has the right to request an administrative hearing to appeal the proposed penalty.

Criminal Penalties. A person who knowingly obtains or discloses individually identifiable health information in violation of the Privacy Rule may face a criminal penalty of up to $50,000 and up to one-year imprisonment. The criminal penalties increase to $100,000 and up to five years imprisonment if the wrongful conduct involves false pretenses, and to $250,000 and up to 10 years imprisonment if the wrongful conduct involves the intent to sell, transfer, or use identifiable health information for commercial advantage, personal gain or malicious harm. The Department of Justice is responsible for criminal prosecutions under the Privacy Rule.

Student Confidentiality Statement

As a student enrolled in a Miami Dade College health care program, I am aware of my responsibility for maintaining confidentiality of patient information that may become available to me in my studies. Such information is protected and considered confidential under applicable federal and state laws (Health Insurance Portability and Accountability Act - HIPAA) and affiliation agreements between the College and affiliating health care agencies. You are encouraged to visit the following website to become familiar with all requirements and violation associated with HIPAA. (http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html)

As a student enrolled in a health care program, I will not copy, reveal, release, transfer, and/or transmit in hard copy and/or in any electronic/digital format any patient information to any third party, except as authorized by law or as authorized by the affiliating agency. I will not use any patient identifying information, such as name or initials, on paperwork or electronic transmissions submitted to the College in the course of my studies. I will only discuss patient information or a patient's medical condition at the affiliating agency in settings away from the general public and only with authorized personnel at the affiliating agency. I further understand that in a classroom setting I will only discuss patients and their medical conditions in a manner that does not in any way identify the patient.

I agree to comply with all patient information privacy policies and procedures of Miami Dade College, the affiliating agency, and federal/state HIPAA regulations. I understand that violating this Confidentiality Statement may result in criminal and civil penalties against me for violating federal and state patient information privacy laws. ***Additionally, I understand that if I violate any College, clinical facility, state/federal HIPAA regulation and/or any portion of this Confidentiality Statement, I will be administratively withdrawn from the enrolled clinical course and may be removed from the program due to the nature of the violation.***

____

Print Student Name

____ ______________

Student Signature **Date**

____

Student Number

Rev: 8/22/03, 8/28/13