Shadowing Agreement Form
Buffalo Dental Implant

Agreement for Pre-Medical Shadowing Observation

Name: (please print)_____

Address: _____

Phone: _____

Email: _____

I understand the shadowing/observation program is provided and done as a public service in the interest of community education.
I understand the observational activity provided does not permit photography by the observer.
I understand that all information about patients, whether it is medical or personal, is absolutely confidential and I will not discuss or repeat anything that I see, read, or hear. I have read and signed the confidential acknowledgement form on page 2.
I understand that as an observer, regardless of background and training, I may not perform any medical procedures. I will not have direct contact with patients, nor have unsupervised access to patients.
I agree to the following statements:

- My required immunizations are current.
- I have not had any exposure to measles, rubella or chickenpox in the last 30 days.

I agree to hold harmless Buffalo Dental Implant and Buffalo Dental Advanced Cosmetics from any present and future liability and/or damages for injuries or illness arising from or growing out of the shadowing/observation experience today.

I understand that business casual dress is minimum requirement. No jeans, sneakers, hats, T-shirts or cell phones are allowed while in the building.

Confidentiality Acknowledgement Form for Observation Activities

Buffalo Dental Implant or Buffalo Dental Advanced Cosmetics has a legal and ethical responsibility to safeguard the privacy of all patients and protect the confidentiality of their protected health information (PHI). Strong federal and state laws govern the privacy of our patients and their health information.

When you participate in an observation experience with us, you are involved in a unique experience. You will be accompanying a healthcare professional for a specified period in a healthcare facility. During this time you will or may be seeing patients with a variety of medical issues and/or you may see, hear, or have access to confidential information relating to these patients. This relates to information past, present, and future.

As a condition of participating in this observational experience, I understand and agree that:

- I must maintain and safeguard the confidentiality of any and all protected health information.
- I will not access use or disclose protected health information unless specifically approved as part of my observational experience. I will maintain all protected health information in the strictest confidence and will not disclose or allow access to protected health information to others.
- Any access to protected health information may be monitored to assure appropriate compliance with system integrity and our policies and procedures.
- If I fail to comply with the above confidentiality guidelines, or if I breach patient confidentiality, this agreement will be terminated and my ability to participate in future activities may be denied.
- I understand that it is my responsibility to protect patient information, confidential information, restricted information, and/or proprietary information even after end date of observation activity. It is unlawful to use or disclose patient information, confidential information, restricted information, and/or proprietary information for any unauthorized purpose.

Applicant Signature: _____ Date: _____