12. Student Visitors in UMSOD Clinics

University of Maryland School of Dentistry Clinical Operations Manual Policy and Procedure

Subject: I. Academic – A. Student Affairs

Department: Clinical Operations - Clinics

Origination Date: 01/01/16

Effective Date: 01/01/16, rev 11/16/2020, 10/4/2021

Scope (applies to): Visitors observing in the clinics

Policy and/or Procedure:

The following is needed for the visitors to be in the clinic and needs to be submitted to Director of Medical Credentialing and Quality Assurance prior to the visit:

- The attached form (Volunteer Form) completed and signed by the visitors.
- The attached Confidentiality Agreement Form.
- If they are going to be outside the splash zone (outside of the cubicles), then no CPR is needed.
- If they are going to be within the splash zone (inside the cubicles), a copy of their current signed CPR copy (front and back).
- Clinic Essentials training and assessments in Blackboard are required upon arrival at UMSOD. The visitor's information needs to be added to the UMB Community Director by the appropriate Department Administrative person so that the visitor has access to Blackboard to review the Clinic Essentials requirements and take and pass the associated assessments in the VISITORS & OBSERVERS FOLDER.
- Proof of COVID-19 vaccination needs to be submitted with the attached signed Visitor forms.
- For those **within the splash zone**: An OSHA Respiratory Questionnaire needs to be completed and signed and sent to the Director of Medical Credentialing and Quality Assurance. The person completes the OSHA Questionnaire form [regarding page 1 respirator section, please **check off both a and b (half face)**], **sign and date page 3, print and** email as a PDF file to: emarkwitz@umaryland.edu . Once the form has received medical clearance, the person is scheduled for a mask fit test.
- For those outside of the splash zone: A KN95 mask and face shield needs to be worn by the visitor while in clinical areas.
- A KN95 face mask needs to be worn at all times while in the UMSOD building.
- Social distancing guidelines are to be performed.

Observation Form for Visitors

The University of Maryland School of Dentistry must abide by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This act sets standards for national electronic health data systems,

simplifies submission of electronic insurance claims. In addition, it contains comprehensive regulations safeguarding the privacy of patients.

Before you will be allowed to observe the treatment of patients in the Dental School, you will need to sign a Confidentiality Agreement. By signing this agreement, you agree to abide by the privacy regulations of HIPAA. Briefly, you cannot disclose any of the following patient information:

- Name
- Address
- Birth date or age
- Telephone & FAX number
- Email address
- Social Security number
- Medical record number
- Health plan beneficiary
- number
- Account number
- Certificate/ license number
- Vehicle ID and serial numbers
- Device ID and serial numbers
- Web addresses
- Internet Protocol address numbers
- Biometric Ids
- Or take full face photographs of patients

Examples of violations

- Telling a friend that someone is a patient at the Dental School.
- Talking about the patient in an identifiable manner in the hallway or elevator.
- Disclosing that someone is a patient in a situation that is not related to the patient's treatment (i.e., telling others about famous people you saw treated at the Dental School).

There are stiff fines for the violation of these regulations,

$50,000 fine + one year in prison for improper disclosure of health information.

$100,000 fine + five years in prison for obtaining health information under false pretenses.

$250,000 fine + ten years in prison for using health information for personal gain.

Confidentiality Agreement

Volunteer Agreement (School retain original. Volunteer retains a copy.)

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Before you will be allowed to observe the treatment of patients in the School of Dentistry, you will need to sign a Confidentiality Agreement. By signing this agreement, you agree to abide by the privacy regulations of HIPAA. Briefly, you cannot disclose any of the following patient information:

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- Address
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- Account number
- Certificate/ license number
- Vehicle ID and serial numbers
- Device ID and serial numbers
- Web addresses
- Internet Protocol address numbers
- Biometric Ids
- Or take full face photographs of patients

Examples of violations

- Telling a friend that someone is a patient at the School of Dentistry.
- Talking about the patient in an identifiable manner in the hallway or elevator.
- Disclosing that someone is a patient in a situation that is not related to the patient's treatment (i.e., telling others about famous people you saw treated at the School of Dentistry).

There are stiff fines for the violation of these regulations,
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CONFIDENTIALITY AGREEMENT

University of Maryland School of Dentistry
650 West Baltimore Street
Baltimore, Maryland 21201

In consideration for being given access to the University of Maryland School of Dentistry ("School of Dentistry") Clinic for purposes of observing treatment being delivered in a clinical area, I agree to abide by all federal and State law pertaining to privacy of medical information, all School of Dentistry policies on privacy and the terms of this Confidentiality Agreement. I understand I will not be permitted to enter the School of Dentistry Clinic unless (1) I sign this agreement and (2) any patient whose treatment I am to observe first consents to my presence.

A. I agree that all personal information I see, hear or otherwise obtain during my visit to the School of Dentistry Clinic is strictly confidential.

B. I have been advised of the importance of complying with all relevant state and federal confidentiality laws including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

C. I agree to keep confidential all patient information, including but not limited to, information (1) provided orally, (2) contained in patient records, (3) obtained incidentally, and (4) maintained in the School of Dentistry's electronic information systems.

D. I may not use personal information or protected health information I acquire at the School of Dentistry Clinic for any purpose.

E. I may only disclose personal or health information I acquire at the School of Dentistry if mandated by a law, regulation or government order, and provided such disclosure does not violate School of Dentistry policy, HIPAA or applicable state law. Further, I must first give the School of Dentistry written notice and an opportunity to object, before I comply with any such mandated disclosure.

F. I understand that my failure to comply with the provisions of this agreement may subject me to disciplinary action by the University of Maryland Baltimore and the School of Dentistry, as well as legal action, including, but not limited to, civil or criminal prosecution.

G. Should I violate this Confidentiality Agreement, I consent to permit the School of Dentistry to release information about my violation to persons, institutions, regulatory authorities and others having a legitimate interest in my violation as it pertains to my fitness as a health professions student and as a licensed health care professional.

READ CONFIDENTIALITY AND OBSERVATION FORM AND AGREED:

Signature______________________________________ Date: __________________________

Print Name_____________________________________

Address: ____, Country: _______________________

Approval Signatures:

Sponsor/Originator: __________________________ Date: _________________________

Department Chairman: ___________________________ Date: _________________________

Approval Dr. DePaola: ___________________________ Date: _________________________

UNIVERSITY OF MARYLAND SCHOOL OF DENTISTRY ("UMSOD")
VISITOR/VOLUNTEER AGREEMENT
(School retain original. Volunteer retain a copy.)

Name of Visitor/Volunteer ____________________________________
Name of
Supervisor_______________________School_______________________Department_____________________

Visitor/Volunteer Activity: ____

_________________________________ Start Date:_________________ End Date: __________________
In consideration of being permitted to participate as a Visitor/Volunteer at UMSOD, I agree as follows:

1. I agree not to perform any work that I am not qualified to perform. I will only do work which I am authorized to do, in advance, by my Supervisor.

2. I will comply with safety standards and all procedures applicable to UMSOD students and faculty. I will conduct myself and my work in accordance with all applicable laws, regulations, policies, rules, standards and instructions. The applicable laws, regulations, policies, rules, standards and instructions have been explained to me and I understand them. I will attend all training sessions required by UMSOD.

3. I am at least 18 years old. I am a U.S. citizen or, if not a U.S. citizen, I certify that my immigration status permits me to work as a Volunteer for the Activity described above.

4. I understand UMSOD assumes no financial responsibility for my health care or treatment. I have health insurance and I am responsible for any charges not covered by my health insurance.

5. I understand I am not covered by general or professional liability insurance for claims and judgments arising out of my activities. I am responsible for any injuries to people or property resulting from my acts, including costs of equipment damaged or broken.

6. I understand UMSOD retains the right to end my work, or deny me access to UMSOD facilities, at any time, for any reason

7. My work as a Volunteer shall not create an employment relationship between UMSOD and me. I am not entitled to participate in UMSOD's benefit programs, including, but not limited to, workers' compensation or health insurance.

8. I agree to be bound by the terms of the USM Policy on Intellectual Property and to assign my patentable inventions to UMSOD upon request.

I agree to assume the risks and responsibilities associated with being a Visitor/Volunteer and I hereby release UMSOD from liability to me or my heirs and survivors with respect to any injury, loss, damage, accident, delay or expense arising from my Volunteer work.

AGREED:________________________________ ___________________________________
Visitor/Volunteer Signature Date

Name PRINTED OR TYPED:____

Address: ____, Country___________________

Dept. Chairman Signature: _________________________________ Date: _______________________

Approval Dr. DePaola: _______________________________ Date: _____________________________