Kaiser Student Packet:

1. Affiliated School Checklist for students
2. Copy of student immunizations **(Program Office will attach)**
3. Flu Declination Form
4. Hep B Vaccine Consent Form
5. Tdap Declination Form
6. TB Symptom Review **(Only fill out if positive for TB)**
7. BLS **(Program Office will attach)**
8. Background/Drug Screen Letter **(Program Office will attach)**
9. KP Learn Instructions **(For your reference, no need to submit back)**
10. 3 Onscreen module tests **(Find on Class Homepage)**
11. Attestation Packet
12. Security Badge Form
13. Sexual Harassment Brochure **(For your reference, no need to submit back)**

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AFFILIATED SCHOOL CHECKLIST FOR STUDENTS
(One form for each student – Please do not type "See attached". Proof must be attached where indicated.)

STUDENT NAME: ***(Please Print)***	**DATE OF BIRTH:** **SOCIAL SECURITY NUMBER:**
Last Name **First Name** **Middle Initial**	**MM/DD/YYYY** **XXX-XX-XXXX**

CONTACT INFO:

Street Address **City** **Zip Code** **(Area Code) Phone Number**

Email address **Emergency Contact Name** **Phone**

TYPE OF STUDENT: NURSING: ☐ RN ☐ BSN ☐ ABSN ☐ MSN ☐ CNS ☐ NP ☐ LVN **OTHER ALLIED HEALTH:** ☐ _____	**DESIRED PLACEMENT DATES:** **START:** _____ **END:** _____
NURSING LICENSE: (IF APPLICABLE) _____ **EXP:** _____	**LIABILITY INSURANCE:** (SCHOOL OR STUDENT) **EXP:** _____ **BACKGROUND CHECK:** _____ **DRUG PANEL SCREENING:** _____

IMMUNIZATION HEALTH RECORDS MUST BE ATTACHED PER CHECKLIST BELOW:

Immunization Requirements	Titer Dates and Results	Vaccination Dates
TB Skin Test (PPD) *Requires 2 skin tests (within last 2-years) *Result must be negative *If positive, must have Chest X-ray	#1 (PPD) Date: _____ Results: _____ #2 (PPD) Date: _____ Results: _____	**Chest X-ray** Date: _____ Results: _____
TB Blood Test – Quantiferon *Result must be negative (within 1-year) *If positive, must have chest x-ray	Date: _____ Results: _____	*TB Symptom Questionnaire must be within 3-months of start date: _____
MMR (Measles/Mumps/Rubella) *Must have positive MMR titer *Negative titer requires 2 MMR vaccinations one month apart	Positive MMR Titer Date: _____	***If NEGATIVE titer*** #1 MMR Date: _____ #2 MMR Date: _____ (must have 2 if born after 1957)
Varicella *Requires positive titer *Negative titer requires 2 doses of varicella at least 1-2 months apart	Positive Varicella Titer Date: _____	***If NEGATIVE titer*** #1 Varicella Date: _____ #2 Varicella Date: _____
Hepatitis B *Requires positive Hep. B titer Requirements: Series 1 and 2 are one month apart. Series 3 is six months after Series 2	Positive Hepatitis B Titer Date: _____	***If NEGATIVE titer*** #1 Hep. B Date: _____ #2 Hep. B Date: _____ #3 Hep. B Date: _____
Tdap *Adult dose within the last 10 years	Date: _____	
Flu Vaccine *Influenza for current calendar year	Date: _____	Flu Attestation/Declination Signed Date: _____
BLS CPR CERTIFICATION: (please provide copy -- front and back)	Type: _____	Date Expires: _____

I CERTIFY THAT I HAVE VALIDATED THE INFORMATION REFERENCED ABOVE FOR THE STUDENT INDICATED ON THIS DOCUMENT.

Verified by:_____ Date:_____

Faculty/ Instructor Signature

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AFFILIATED SCHOOL CHECKLIST FOR STUDENTS
(GSAA Supplemental information only)

BACKGROUND CHECK-

Criminal Background Check and Drug Screening are required for all students placed at a Northern California Kaiser Permanente Medical Center, Outpatient Clinic/Medical Office Building, Home Health & Hospice, or Appt & Advice Call Center.

Effective 1/1/2008, a student with a background check that indicates any of the following felony and/or misdemeanor convictions within the last 7 years is NOT eligible for clinical placement:

- *Violent crimes such as murder, rape, sexual assault and robbery, kidnapping, attempted murder, assault with deadly weapons.*
- *Crimes involving theft, embezzlement, burglary, forgery, fraud, arson, identity theft.*
- *Sex crimes including sexual molestation and sex crimes against children, or any conviction for which a candidate is required to register as a sex offender with a state or federal government agency.*
- *Drug related crimes such as drug theft, sales, distribution, manufacturing and possession of controlled substances.*
- *Multiple convictions (more than one conviction for same or different crime).*
- *Name posted on any government sanctioned or debarred list.*

Northern California

KAISER PERMANENTE®

Name _____
Department _____
Medical Record # _____
Employee ID _____
DOB _____

Influenza Vaccine Form 2020-2021

Please fill out **Part A** if you have had a flu vaccine outside of KP or **Part B** if you decline the flu vaccine

Part A (provide verification to EHS if available)

☐ **I had the 2020-2021 Flu Vaccine** at: _____

On: _____ (Approximate Date is OK) **You can skip Part B and sign at the bottom**.

Part B **If you have decided not to get the 2020-2021 Flu Vaccine today, please fill out the following:**

I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease that kills; as many as 60,000 Americans may die every year from influenza-related causes.
- Influenza virus may be shed for up to 24 hours before symptoms begin.
- Some people with influenza have no symptoms, but can still transmit to others. Influenza virus changes often, making annual vaccination necessary. Immunity following vaccination takes 2 weeks to develop. In California, influenza usually circulates in November through March or April.
- I understand that due to my occupational exposure to aerosol transmissible diseases, I may be at risk of acquiring seasonal influenza. I have been given the opportunity to be vaccinated against this infection at no charge to me. However, I decline this vaccination at this time. I understand that by declining this vaccine, I continue to be at increased risk of acquiring influenza. If, during the season for which the CDC recommends administration of the influenza vaccine, I continue to have occupational exposure to aerosol transmissible diseases and want to be vaccinated, I can receive the vaccination at no charge to me. I acknowledge that influenza vaccination decreases risk of transmission of influenza and its complications that include death, to patients, my coworkers, my family, and my community.

☐ ***Because I have refused vaccination for influenza, I have been advised that in order to protect the safety of my patients and myself during this flu season, I will be required to wear a mask if there is a county public health or Kaiser Permanente mandate. If there is no mandate for my area, then I am strongly encouraged to wear a mask when delivering patient care or working in patient care areas.**

Knowing these facts, I choose to decline vaccination at this time. I may change my mind and accept vaccination later, if vaccine is available. I have read and fully understand this declination form.

I **decline vaccination** for the following reason(s). Please check all that apply.

☐ 1) I understand that the influenza vaccine cannot transmit influenza, but I worry I will get influenza if I get the vaccine.
☐ 2) I worry I may feel sick after receiving the influenza vaccine or that the vaccine may be harmful to my health.
☐ 3) I do not think the vaccine works.
☐ 4) I am already wearing a mask at work.
☐ 5) I am not worried about getting influenza. *Please NOTE: even those without symptoms can transmit influenza to others.*
☐ 6) I do not like needles.
☐ 7) My religious beliefs prohibit vaccination.
☐ 8) I have previously had a severe allergic reaction (eg, anaphylaxis) to an influenza vaccine. *Please NOTE: we have options for influenza vaccinations that be given safely even to individuals with severe egg allergies.*
☐ 9) I have previously developed Guillain-Barre syndrome within 6 weeks of receiving a previous influenza vaccination.
☐ 10) I do not wish to say why I decline.
☐ 11) Other reason – please tell us.
_____

Signature _____ Date signed _____

☐ Entered into EHS Database/KIDDS

KAISER PERMANENTE
Kaiser Foundation Hospitals
The Permanente Medical Group, Inc.

HEPATITIS B VACCINE CONSENT/DECLINATION

Kaiser Permanente Employee: ☐ Yes ☐ No

IMPRINT AREA

OCCUPATION	DEPARTMENT	LOCATION	SS #

Hepatitis B virus (HBV) is an important cause of viral hepatitis. Its most important method of transmission is from the blood of acutely or chronically infected people. Health care workers are at increased risk of HBV infection because of contact with blood products. The serious complications and results of HBV infection include liver damage, cirrhosis of the liver, chronic active hepatitis, cancer of the liver and death. Between 6% and 10% of young adults with HBV infection become carriers of hepatitis B virus. Chronic active hepatitis develops in over 25% of such carriers and often progresses to cirrhosis of the liver. Hepatitis B-related liver cancer is developed by 4% of carriers. There is no specific treatment for hepatitis B infection.

The hepatitis B virus vaccine is 80-95% effective in preventing hepatitis in susceptible people. The vaccine is given intramuscularly in three doses, with the second and third doses given one and six months after the first dose. Recombinant hepatitis B vaccine is contraindicated in the presence of hypersensitivity to yeast or any component of the vaccine. The most common side effect has been limited to soreness or redness at the injection site. Systemic complaints could include fatigue/ weakness, fever, headache, and malaise. Because of the long incubation period of hepatitis B, it is possible for unrecognized infection to be present at the time the vaccine is given and vaccination may not prevent hepatitis B in these cases. The duration of protection is probably more than five years but this, or the need for boosters, is yet to be determined.

I, the undersigned, have read the above and understand the risks and benefits of the hepatitis B vaccine. I have had the opportunity to have my questions answered satisfactorily.

PLEASE CHECK: ☐ I request that the hepatitis B vaccine be administered to me.

HEPATITIS B VACCINE DECLINATION (FOR KAISER PERMANENTE EMPLOYEES ONLY)

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

☐ I presently decline the hepatitis B vaccine.

☐ I have already had the hepatitis B vaccine. Year received _____.

DATE	NAME (PRINT)	SIGNATURE	WITNESS

ANTIBODY TEST RESULTS/DATE	PHYSICIAN SIGNATURE

To be completed by Injection Station nurse:

TYPE OF VACCINE	DOSE*	SITE	DATE	NURSE'S SIGNATURE
1.				
2.				
3.				

*Pediatric dose may be lower and must be specified.

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Print Name: _____

Tetanus, Diphtheria & Pertussis (Tdap) Declination

I have had the opportunity to review the latest Centers for Diseases Control educational material (Vaccine Information Sheet Tdap 04/01/2020) and ask questions regarding: 1) Tetanus, diphtheria & pertussis and their risks to health care personnel, and 2) the potential risks and benefits of the Tetanus, diphtheria & pertussis (Tdap) vaccine.

Please select only ONE of the following:

☐ I have received the **Tdap** vaccine on: _____ (approximate date)

☐ I have received a **Td Booster** on: _____ (approximate date)

☐ **I have elected NOT to receive the Tdap vaccine at this time.** I understand that I may elect to receive the Tdap vaccine at a later time.

I understand that due to my occupational exposure to aerosol transmissible diseases, I may be at risk of acquiring an infection with pertussis. I have been given the opportunity to be vaccinated against this disease or pathogen. However, I decline the Tdap vaccination at this time. I understand that by declining the Tdap vaccine, I continue to be at risk of acquiring a serious disease. If in the future, I continue to have occupational exposure to aerosol transmissible disease and want to be vaccinated, I can receive the Tdap vaccination.

Signature: _____ Date: _____

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Greater Southern Alameda Area

Name: _____

Address: _____

Subject: TUBERCULOSIS MEDICAL SURVEILLANCE

Your TB Medical Surveillance must be completed UNLESS ADVISED OTHERWISE. Failure to complete this screening may result in your being placed on administrative leave without pay until compliance is achieved. In order to meet healthcare organization accreditation and regulatory compliance requirements, all Employees, including MD's, Contracted employees, Students and Volunteers must participate in periodic TB medical screening. Your participation is mandatory and a condition of continued service. (California Division HR Policy 5.02).

	YES	NO
1. Have you ever had Tuberculosis?	_____	_____
➢ If yes, when? _____		
➢ If yes, were you medicated? _____		
2. Have you ever been in therapy to prevent TB?	_____	_____
➢ If yes, for how long? _____		
➢ What was the year? _____		
3. Have you ever been informed of an abnormal Chest X-ray?	_____	_____
4. Have you ever received BCG Vaccine?	_____	_____
(A vaccine given in foreign countries to prevent TB. It leaves a scar on your arm similar to a smallpox scar.)		
➢ If yes, what year? _____		
➢ If so, when was your last skin test? _____		
5. Have you ever had a positive TB skin test?	_____	_____
➢ If yes, when? _____		
➢ If so, where? _____		

****

In the past **12-months** have you experienced the following:	YES	NO
1. Had a chronic (recurrent) cough?	_____	_____
2. Had unexplained recurrent fevers?	_____	_____
3. Had recurrent night sweats?	_____	_____
4. Coughed up or spit blood?	_____	_____
5. Had any unexplained weight loss?	_____	_____
6. Experienced unexplained chronic fatigue?	_____	_____
7. Been advised you are immunosuppressed for any reason?	_____	_____

Signature: _____ **Date:** _____

NOTE: This TB Questionnaire was sent to you because your records show that you have had a documented positive PPD skin test.

Clinical RN / KP Learn Online Training Modules Access Log-in

1. **IMPORTANT:** A new security process for logging into KP Learn. First, you must call our IT Help Desk at (1-888-457-4872) and put in a direct service ticket for a PingID number. It takes 48-hours to receive a temporary PingID number. Students must call back after 48-hours to receive that number. Once you received it, then you can access KP Learn.

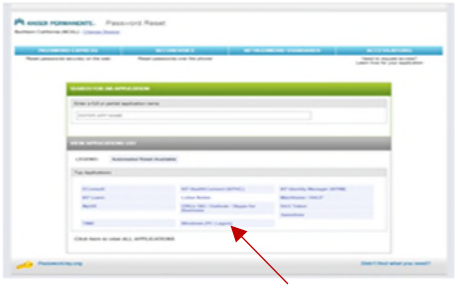
2. You cannot access KP Learn if using a MAC computer, HP Chromebook, or any Mobile Device. Follow the instructions as noted below to access KP Learn and complete the modules:

Class ID #	Clinical RN - Description of Required KP Learn Online Modules
0000871248	COVID-19 Training 2021
0000859923	COVID-19 Symptom Self-Check and Badge Attestation
0000869568	2021 Ethics and Compliance Training for **Contingent** Workers
0000872519	Initial OSHA Clinical Safety Training for CA (Hospital & MOBs) (includes EOC and Waste) 2021
0000873632	2021 Prevention of Central Line Associated Blood Stream Infections (CLABSI) & Catheter Associated Urinary Tract Infections
0000873631	2021 Preventing Healthcare Associated Infections (HAI) includes Hand Hygiene (HH) Training
0000873633	2021 Prevention of Surgical Site Infections (SSI)
0000856933	Prevention of Workplace Violence
0000871666	Protecting PHI at Kaiser Permanente 2021
0000869567	2021 **Contingent** Worker Onboarding and Attestations

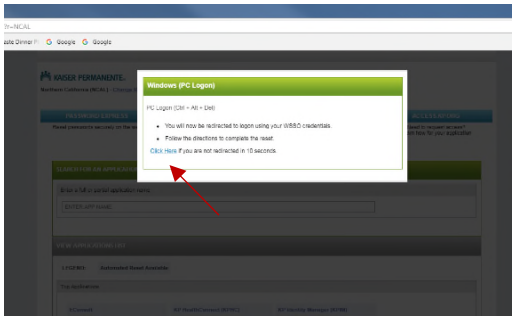
1. Open Internet Explorer and type in **https://learn.kp.org**

2. Click on the **Green Button**: Log on to KP Learn

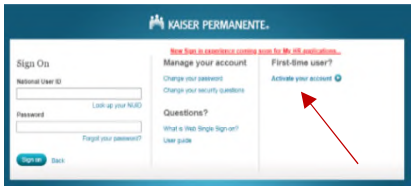
3. Open Internet Explorer – if not working you can use Google. Type in **password.kp.org**



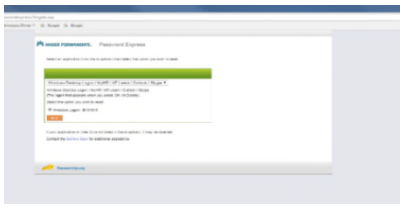
4. Then next screen pop-up **Click Here**



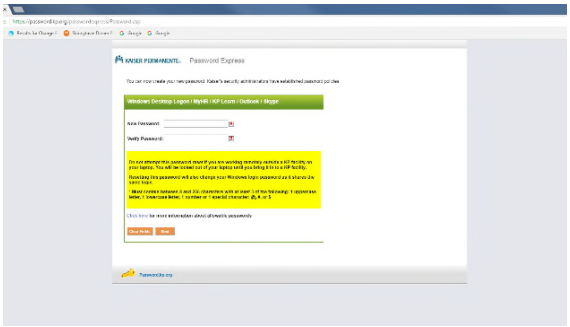
5. You will be redirected to a Single Sign-On. If it's your first time logging in, please **Activate Your Account**.



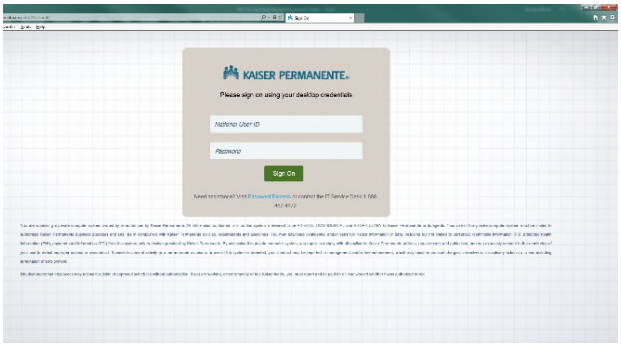
6. Click on the Drop-down menu, select **Windows Desktop Logon/ MyHR /KP Learn/ Outlook / Skype.** Then select your NUID number.



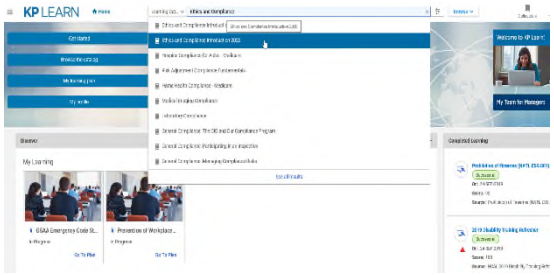
7. Under Password Express, please re-enter your password.



8. New Sign-In Page for KP Learn

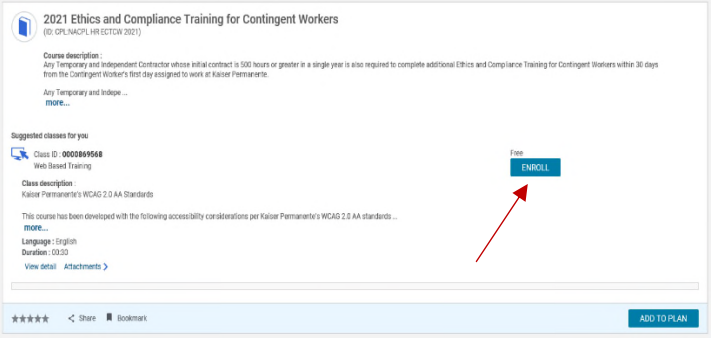


9. Search the Learning Catalog for the Course, type in **0000869568, (or) 2021 Ethics and Compliance Training for Contingent Workers,** in the search field box and select.
10. Allow **approximately 90-minutes to complete each module.** If you need to interrupt your training, see Steps



11. When you find the Course **"2021 Ethics and Compliance Training for Contingent Workers"** click **Enroll.**

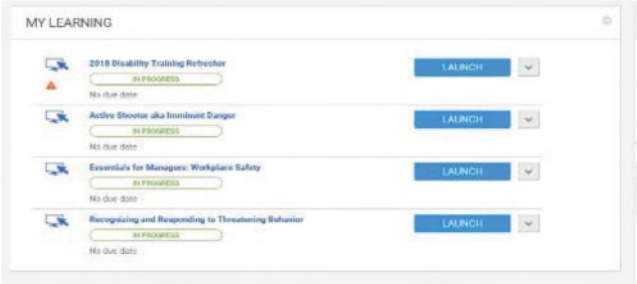
*Note: The **"Offered As:"** section must say ***"Web Based Training"*** in order for the training to properly work.

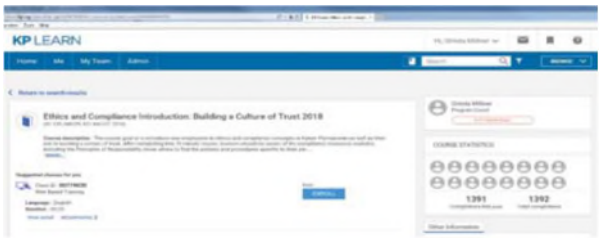


12. To properly exit the Web-based training module, use the course navigation buttons.

- If you need to leave the course website before you finish the course, click on the EXIT button at the top right of the screen.
- **DO:** Use the course navigation exit buttons to receive credit for the course completion.
- **DON'T:** Use the browser window close button as this may result in no completion credit.

13. Then log in again at **Learn.kp.org** when you are ready to resume.
14. Under **My Learning** click on **"Launch"** for **2021 Ethics and Compliance Training for Contingent Workers.** You will be returned to your last completed section.



15. Remember to print out your Certificate of Completion for all the Modules completed. That is your proof of completion and a required item to include in your packet.	
If you are still having difficulty accessing or using KP Learn, please call the **IT Help Desk at 1-888-457-4872.** Please understand that the Student Placement Coordinator does not have the capabilities to assist you with troubleshooting issues. If you are unable to print out your Certificate of Completion, notify the Student Placement Coordinator, during your orientation.	

KAISER PERMANENTE®

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CONFIDENTIALITY AGREEMENT

Instructions: 1. To ensure efficient and effective service, submit form online. Immediate confirmation will be sent to you upon receipt of your online submittal.
2. If online submittal is not feasible, fax your form to HR Service Center (877) 477-2329 or interoffice mail to HR Service Center, Alameda.
3. Remember to print copy of form before submitting.
4. The Effective Date represents the date the Confidentiality Agreement is signed.

* Employee ID	* Work Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
* Employee First Name	Employee Middle Name	* Employee Last Name
* Job Title	* Location	

AGREEMENT

In my job, I may see or hear confidential information in any form (oral, written, or electronic) regarding:

- HEALTH PLAN MEMBERS AND PATIENTS AND/OR THEIR FAMILY MEMBERS (such as patient records, test results, conversations, financial information)
- EMPLOYEES, PHYSICIANS, VOLUNTEERS, CONTRACTORS (such as employment records, corrective actions/disciplinary actions)
- BUSINESS INFORMATION (such as member rates, marketing plans, financial projections)

I will protect the confidentiality of this information. Access to this information is allowed only if I need to know it to do my job.

I AGREE THAT:

1. I will protect the privacy of our patients, members, and employees.
2. I will not misuse confidential information of patients, members, employees or Kaiser Permanente (including confidential business and personnel information) and I will only access information I have been instructed or authorized to access to do my job. With respect to Protected Health Information, I will only access or use such information as it is necessary to provide medical care to the member and/or patient or as necessary for billing and payment or health plan operations.
3. I will not access my family members' PHI. I will not access my own medical records unless my job duties authorize me to have access to electronic medical records (for example, KP HealthConnect). Instead, I will follow the same procedures that apply to non-employee health plan members.
4. I will not share, change, remove or destroy any confidential information unless it is part of my job to do so. If any of these tasks are part of my job, I will follow the correct department procedure or the instructions of my supervisor/chief of service (such as shredding confidential paper). If a demand is made upon me from outside Kaiser Permanente to disclose confidential information, I will obtain approval from my supervisor before disclosing such information.
5. I understand that inappropriate or unauthorized access, use or disclosure of PHI may result in legally required reporting to governmental authorities, including my name.
6. I know that confidential information I learn on the job does not belong to me and that Kaiser Permanente may take away my access to confidential information at any time.
7. If I have access to electronic equipment and/or records, I will keep my computer password secret and I will not share it with any unauthorized individual. I am responsible if I fail to protect my password or other means of accessing confidential information.
8. I will not use anyone elses password to access any Kaiser Permanente system unless I am authorized to do so. If I am authorized to do so (e.g., in order to perform computer systems maintenance), I will follow procedures to ensure the password is changed and that confidential information is not at risk.
9. I will lock my computer when I step away to prevent someone else accessing the computer under my logon. I understand that I am personally responsible for any accesses under my logon.
10. If I leave Kaiser Permanente I will not share any confidential information that I learned or had access to during my employment.
11. On termination of my employment, I will promptly return to Kaiser Permanente all originals and copies of documents containing Kaiser Permanente's information or data in my possession or control, unless the documents were provided to me as part of my employment record.

HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist

Next Page >

* First Name	Middle Name	* Last Name
* Employee ID	* Work Phone Number (###)###-####	* Effective Date (mm/dd/yyyy)

AGREEMENT - (Continued)

Examples of Breaches of Confidentiality (What you should NOT do.)

These are examples only and do not include all possible breaches of confidentiality.

- Unauthorized reading of patient account information.
- Unauthorized reading of a patient's chart.
- Unauthorized access to my own medical information if my job duties do not authorize me to have access to electronic medical records (for example, KP HealthConnect).
- Accessing medical information of friends, co-workers, family members, or anyone else, unless it is required for my job.
- Discussing confidential information in a public area such as a waiting room or elevator.
- Discussing or otherwise sharing confidential information with anyone in your personal life, including family members or friends.
- Accessing records for any reason other than for legitimate business purpose.
- Accessing records of family, friends, co-workers, patients in the media, well known political figures, celebrities, or anyone else about whom you are curious.
- Sending confidential information to your personal e-mail account, unless you are authorized to do so and the information is transmitted in accordance with required procedures (e.g., encrypted).
- Saving confidential electronic information to a KP-owned or non-KP-owned flash drive, CD, or any other removable or transportable storage device unless you first secure permission as outlined in the Secure Electronic Storage provisions of the KP Information Security Policy.
- Saving confidential electronic information to a KP-owned or non-KP-owned workstation, laptop computer, personal digital assistant, or any other mobile computing device unless you first secure permission as outlined in the Secure Electronic Storage provisions of the KP Information Security Policy.
- Using personal devices (digital cameras, camera phones) to take photographs that may include confidential information as the primary subject or in the background.
- Documenting or referencing confidential information on any social networking site, such as Twitter, My Space.
- Telling a co-worker your password so that he or she can login to your work.
- Telling an unauthorized person the access codes for employee files or patient accounts.
- Being away from your workstation while you are logged into an application, without locking your system to protect confidential information.
- Unauthorized use of a co-worker's password to logon to a Kaiser Permanente information system.
- Unauthorized use of a user ID to access employee files or patient accounts.
- Allowing a co-worker to use your secured application* for which he/she does not have access after you have logged in.

* secured application = any computer program that allows access to confidential information. A secured application usually requires a user name and password to log in.

KAISER PERMANENTE®

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CONFIDENTIALITY AGREEMENT

* First Name	Middle Name	* Last Name
* Employee ID	* Work Phone Number (###)###-####	* Effective Date (mm/dd/yyyy)

AGREEMENT - (Continued)

12. I understand that I am responsible for my access, use, or misuse of confidential information and know that my access to confidential information may be audited.
13. I understand that my supervisor/chief of service or other managers and/or the Compliance Hot Line are available if I think someone is misusing confidential information or is misusing my password. I further understand that Kaiser Permanente will not tolerate any retaliation because I make such a report.
14. I understand that patient privacy and security is included in various training programs within Kaiser Permanente (for example: New Employee training, Annual Compliance Training), and by taking such training, I understand the obligations of confidentiality. I further understand that it is my responsibility to secure guidance from my supervisor or manager in the event any questions exist relating to my obligations regarding confidentiality.
15. I understand that this policy is not meant to prohibit any protected rights provided for in the National Labor Relations Act (for represented employees).
16. I understand that failure to comply with this agreement may result in disciplinary action up to and including termination of employment or other relationship with Kaiser Permanente. I understand that I may also be subject to other remedies allowed by law.
17. I understand that I must also comply with any laws, regulations, and other Kaiser Permanente policies, including the Principles of Responsibility that address confidentiality.
18. By signing (or selecting the submit button below), I agree that I have read, understand, and that I will comply with this Confidentiality Agreement.

SIGNATURE (Required if not submitted online)

* Employee Signature	* Date (mm/dd/yyyy)

After completing the form:
1. Print form to keep a copy for your records.
2. Print another copy and sign it for your supervisor.
3. Press the Submit button.
4. Wait for a pop-up screen to confirm the form has been submitted. (This may take a few minutes.)
5. Submit online or fax your form to HR Service Center (877) 477-2329 or interoffice mail to HR Service Center, Alameda.

KAISER PERMANENTE®

2860

CHILD ABUSE REPORTING REQUIREMENTS

Instructions: 1.To ensure efficient and effective service please, submit form online.
2. Items marked with an asterisk (*) are required fields.
3. Remember to print copy of form before submitting.
4. Immediate confirmation will be sent to you upon receipt of your online submittal.

* Employee ID	* Home Phone (###) ###-####	* Work Phone (###) ###-####	* Effective Date (mm/dd/yyyy)

* First Name	Middle Name	* Last Name

1. REQUIREMENTS

Section 11166 of the Penal Code requires any child care custodian, health practitioner, or employee of a child protective agency who has knowledge of or observes a child in his or her professional capacity or within the scope of his or her employment who he or she knows or reasonably suspects has been the victim of child abuse or who he or she knows or reasonably suspects that a child is suffering serious emotional damage or is at substantial risk of suffering serious emotional damage to report the known or suspected instance of child abuse to a child protective agency immediately or as soon as practically possible by telephone and to prepare and send a written report thereof within 36 hours of receiving the information concerning the incident.

The identity of all persons who report shall be confidential and disclosed among agencies receiving or investigating mandated reports, to the district attorney in a criminal prosecution, or in an action initiated under Section 602 of the Welfare and Institutions Code arising from alleged child abuse, or to counsel appointed pursuant to subdivision (c) of Section 317 of the Welfare and Institutions Code, or to the county counsel or district attorney in a proceeding under Part 4 (commencing with Section 7800) of Division 12 of the Family Code or Section 300 of the Welfare and Institutions Code, or to a licensing agency when abuse or neglect in out-of-home care is reasonably suspected, or when those persons waive confidentiality, or by court order.

“Health practitioner” includes physicians and surgeons, psychiatrists, psychologists, dentists, residents, interns, podiatrists, chiropractors, licensed nurses, dental hygienists, optometrists, or any other person who is licensed under Division 2 (commencing with Section 500) of the Business and Professions Code; marriage, family and child counselors, emergency medical technicians I or II, paramedics, or other person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code; psychological assistants registered pursuant to Section 2913 of the Business and Professions Code, marriage, family and child counselor trainees as defined in subdivision (c) of Section 4980.44 of the Business and Professions Code; state or county public health employees who treat minors for venereal disease or any other condition; coroners; paramedics; and religious practitioners who diagnose, examine, or treat children.

Volunteers whose duties include direct contact with and supervision of children are not mandated reporters, but are encouraged to report instances of child abuse and neglect.

Your department chief or supervisor should be notified whenever you believe you may be required to report suspected child abuse.

I understand and agree, if in a “Child Care Custodian” or “Health Practitioner” classification, as defined above, to comply fully with the above-cited provisions of the California Penal Code, in accord with procedures established by my Employer/Medical Center.

2. EMPLOYEE SIGNATURE

Signature - (Required if not submitted online).

* Employee Signature	* Date (mm/dd/yyyy)

Facility / Department

Submit

After completing the form:
1. Print form to keep a copy for your records.
2. Press the Submit buttion.
3. Wait for a pop-up screen to confirm the form has been submitted. (This may take a few minutes.)

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772

KAISER PERMANENTE®

2950 ELDER AND DEPENDENT ADULT ABUSE REPORTING REQUIREMENTS

Instructions: 1. To ensure efficient and effective service please, submit form online.
2. Items marked with an asterisk (*) are required fields.
3. Remember to print copy of form before submitting.
4. Immediate confirmation will be sent to you upon receipt of your online submittal.

* Employee ID	* Home Phone (###) ###-####	* Work Phone (###) ###-####	* Effective Date (mm/dd/yyyy)
* First Name	Middle Name	* Last Name	

1. ELDER AND DEPENDENT ADULT ABUSE REPORTING REQUIREMENTS

California Welfare and Institutions (W&I) Code Section 15659 requires Kaiser Permanente Medical Program to provide all "health professionals" and "care custodians" information concerning their responsibility to report incidents of observed, known, or suspected elder and dependent abuse. All health practitioners or care custodians must sign a statement acknowledging receipt and understand of the **mandatory** elder and dependent abuse reporting requirements. Kaiser Permanente must retain the signed statement.

Elders are persons 65 years of age or older. **Dependent adults** are persons between the ages of 18 and 64 with physical or mental limitations such as physical or developmental disabilities or age-diminished physical or mental abilities. The law also expressly includes any person between the ages of 18 and 64 who is admitted as an inpatient to an acute care hospital or other 24-hour facility as a dependent adult. (W&I Code Sections 15610.23, 15610.27 and 15701.2)

Abuse of and elder or dependent adult means either of the following:
(a) Physical abuse, including lewd or lascivious acts, neglect, financial abuse, abandonment, isolation, abduction, or other treatment with resulting physical harm or pain or mental suffering; or
(b) The deprivation by a care custodian of goods or services that are necessary to avoid physical harm or mental suffering. (W&I Code Section 15610.07)

At Kaiser Permanente, a physician, nurse, and licensed or unlicensed health care professional, including administrative and support staff, who, in his or her professional capacity, or within the scope of his or her employment, has observed or has knowledge of elder and/or dependent abuse, or reasonably suspects elder and/or dependent abuse, **shall report by telephone immediately or as soon as practically possible and by written report within two (2) working days** as follows:
(a) to the long-term care ombudsmen or the local law enforcement agency when the abuse is alleged to have occurred in a long-term care facility;
(b) to the State Department of Mental Health, the State Department of Developmental Services, or the local law enforcement agency if the abuse is alleged to have occurred in a state mental health hospital or state developmental center; or,
(c) to the adult protective services agency or the local law enforcement agency when the abuse is alleged to have occurred anywhere else. (W&I Code Section 15630)
All incidents should be documented and forwarded to the appropriate agency in accordance with local medical center procedures.

I certify that I have read and understand this statement and will comply with the requirements of the Elder and Dependent Abuse Reporting Law.

2. SIGNATURE

* Employee Signature	* Date (mm-dd-yyyy)
Facility / Department	

Submit

After completing the form:
1. Print form to keep a copy for your records.
2. Press the Submit buttion.
3. Wait for a pop-up screen to confirm the form has been submitted. (This may take a few minutes.)

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772

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KAISER PERMANENTE®

Domestic Violence Reporting Requirements

Employee ID	First Name	Last Name	Date

Domestic Violence: *Any stated threat or infliction against an adult or adolescent, intimate partner, past or present, by means of physical violence, threats, emotional abuse, harassment, or stalking that is directed at achieving compliance from or control over the victim.*

California State law (health and Safety Code section 1259.5) requires that a care provider knows how to identify and handle patients whose injuries or illnesses are attributed to domestic violence.

Victims of domestic violence may try to hide the abuse. Abuse may start or increase during pregnancy.

Be alert to: Behavioral Cues

- nervous, inappropriate laughter, lack of eye contact, minimizing serious injuries
- overly attentive, hovering partner
- frequent user of health care services, especially for psycho-somatic complaints

Physical Indicators

- central distribution of injuries- face, throat, neck, chest, abdomen, breasts, genitals
- delay between onset of injury and presentation for treatment
- multiple injuries in various stages of healing

Under California Penal Code, Section 11160, suspected domestic violence must be reported. Failure to report such abuse is a misdemeanor and punishable by a fine of $1000.00 and / or jail term of six months.

It is a care provider's responsibility to report when a patient seeks medical treatment when injuries have been inflicted upon them, regardless of the patient's wish to self-report.

1. *Oral report must be made as soon as possible.*
2. *Written report must be competed and sent within 48 hours to a law enforcement agency where incident occurred. Reports may be faxed to reporting agency.*

Documentation Responsibilities as a Healthcare Provider: *Remember that the reporting form is not a substitute for complete documentation.*

*Refer to your local KP Administrative policy titled: **Abuse – Assessment, Management and Reporting Child, Elder/Dependent Adult and Domestic Violence Policy** for detailed description of suspected abuse signs and symptoms, treatment, reporting, documentation, and web sites available to learn more about abuse.*

EMPLOYEE SIGNATURE (Required if not submitted online)

Employee Signature _____ Date (mm/dd/yyyy) _____

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Employee ID	First Name	Last Name	Date

Staff Rights

Kaiser Permanente (KP) California Human Resources Policy 2.03 clarifies your right as a caregiver to request to refrain from participation in aspects of patient care or treatment due to moral, ethical, or religious beliefs. KP will reasonably accommodate a caregiver's moral, ethical or religious beliefs as long as they do not negatively affect patient care, safety, or treatment or cause undue hardship to KP.

If you feel this applies to you, you must notify your manager prior to the denial of service. A form to request accommodation(s) is attached. Your manager will discuss possible accommodations with you, which may include (but are not limited to):

1. Revised procedures;

2. Job restructuring which permits you to perform the essential functions of the job and which do not negatively affect patient care, safety, or treatment or cause undue hardship to KP;

3. Reassignment to a similar, vacant position in accordance with any applicable collective bargaining agreement or policy.

KP will make the final determination as to what, if any, accommodation(s) will be provided and how aspects of patient care will be performed. Further, in emergency situations in which the immediate nature of a patient's need will not allow for substitution, the patient's right to receive necessary care takes precedence over the exercise of the caregiver's individual moral, ethical, or religious beliefs.

I have read the above information and am aware of the outlets available to me should I encounter a conflict with my personal ethics, religious beliefs, or cultural values while on the job.

EMPLOYEE SIGNATURE (Required if not submitted online)

Employee Signature _____ Date (mm/dd/yyyy) _____

*Additional information can be found on MYHR under HR policies.

KAISER PERMANENTE®

Kaiser Health Plan Member Rights and Responsibilities & Kaiser Foundation Hospital Patient Rights and Responsibilities

Employee ID:	Department:	Facility:
First Name:	Last Name:	

AMBULATORY:

KAISER PERMANENTE respects the rights of members and recognizes that each member is an individual with unique health care needs and (because of the importance of respecting each member's personal dignity) provides considerate, respectful care focused upon the member's individual needs.

It is the responsibility of every member of the health care team to assure that each health plan member or surrogate decision maker has the opportunity to exercise their rights in accordance with the California Administrative Code. Furthermore, Kaiser Permanente recognizes the responsibility to inform and educate staff to ensure that this policy is adhered to. Also, it is the responsibility of every member to make their needs and wishes known.

All personnel shall observe these member rights.

A. KAISER PERMANENTE MEMBER RIGHTS AND RESPONSIBILITIES

A member is defined as a Kaiser Permanente health plan member

Kaiser Permanente is committed to treating members in a manner that respects their rights and informs them of their rights and responsibilities as follows:

1. Members have a right to:
    - Receive information about Kaiser Permanente, its services, its practitioners and providers, and members' rights and responsibilities.
    - Be treated with respect and recognition of their dignity and right to privacy.
    - Participate with practitioners in decision making regarding their health care.
    - A candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
    - Voice complaints or appeals about Kaiser Permanente or the care provided.

2. Members have a responsibility to:
    - Provide, to the extent possible, information that the managed care organization and its practitioners and providers need in order to care for them.
    - Follow the plans and instructions for care that they have agreed on with their practitioners.
    - Keep appointments and when unable to do so for any reason, notify the responsible medical care provider or the medical offices.

KAISER PERMANENTE

Kaiser Health Plan Member Rights and Responsibilities & Kaiser Foundation Hospital Patient Rights and Responsibilities

- Accept ownership for their actions if they refuse treatment or do not follow the medical care providers instructions.
- Assure financial obligations for their health care treatment are fulfilled as promptly as possible.
- Provide accurate and complete information about present complaints, past illnesses, hospitalization, medications, and other matters relating to their health.
- Report unexpected changes in their conditions to the medical care provider.
- Report whether he/she clearly comprehends a contemplated course of action and what is expected.

3. Kaiser Permanente assures members of their right to voice complaints and appeals. Questions or concerns may be directed to the Patient Relations/Health Plan Office (s).

Members can also voice concerns by calling the Department of Corporations act 1-800-400-0615.

HOSPITAL:

Kaiser Foundation Hospital - San Leandro (KFH-San Leandro) respects the rights of patients and recognizes that each patient is an individual with unique health care needs and provides considerate, respectful care focused upon the patient's individual needs. Therefore, the hospital and medical staff have adopted a written policy on patients' rights (Patient Rights and Responsibilities PR.16.01)

It is the responsibility of every member of the health care team to assure that each patient or surrogate decision maker has the opportunity to exercise their rights in accordance with the California Administrative Code. Furthermore, Kaiser Foundation Hospital-San Leandro recognizes the responsibility to inform and educate staff to ensure that this policy is adhered to. Also, it is the responsibility of every patient to make their needs and wishes known.

Therefore, every patient receives a written statement of these rights upon admission and a list of these patient rights are posted in appropriate places within the hospital so that the rights may be read by patients.

B. KFH- SAN LEANDRO PATIENT RIGHTS AND RESPONSIBILITIES

A patient is defined as a person who is seen in the Emergency Department and/or is hospitalized as an inpatient or outpatient at the KFH- San Leandro.

Patients have the right to:

1. Patient's shall be able to exercise these rights without regard to race, ethnicity, color, national origin, ancestry, religion, culture, language, sex (including gender, gender identity, gender expression), sexual orientation, age, genetic information, marital status, registered domestic partner status, veteran's status, medical condition, socioeconomic status, educational background, physical or mental disability, or the source of payment
2. Considerate and respectful care.

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Kaiser Health Plan Member Rights and Responsibilities & Kaiser Foundation Hospital Patient Rights and Responsibilities

3. Knowledge of the name of the licensed healthcare practitioner acting within the scope of his or her professional licensure who has primary responsibility for coordinating the care and the names and professional relationships of physicians and non-physicians who will see the patient.
3. Receive information from the physician about the illness, the course of treatment, and the prospects for recovery in the terms that the patient can understand.
4. Receive as much information about any proposed treatment or procedure as the patient may need in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or the treatment, the medically significant risks involved in this treatment, alternate courses of treatment or non-treatment, and the risks involved in each, and to know the name of the person who will carry out the procedure or treatment.
5. Participate actively in decisions regarding medical care. To the extent permitted by law, this includes the right to refuse treatment including forgoing or withdrawing life-sustaining treatment or withholding resuscitative services.
7. Have the hospital demonstrate respect for the following patient needs:
    a. Full consideration of privacy concerning the medical care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly. The patient has the right to be advised as to the reason for the presence of any individual.
    b. Confidential treatment of all communications and records pertaining to the patient's care and stay in hospital. Written permission shall be obtained before the medical records can be made available to anyone not directly concerned with the care except in the case of abuse/assault reporting by mandated reporters.
8. Reasonable responses to any reasonable requests made for service.
9. Leave the hospital even against the advice of physicians.
9. Reasonable continuity of care and to know in advance the time and location of appointments as well as persons providing the care.
10. Be advised if hospital/personal physician proposes to engage in or perform human experimentation affecting care or treatment. The patient has the right to refuse to participate in such research projects.
11. Be informed of continuing health care requirements following discharge from the hospital.
12. Examine and receive an explanation of the bill regardless of source of payment.
13. Know which hospital rules and policies apply to the patient's conduct while a patient.
14. Have all patients' rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.
15. Have visitors as described below:
    a. Designate visitors of his/her choosing, if the patient has decision making capacity, whether or not the visitor is related by blood or marriage, unless:
        - No visitors are allowed

Kaiser Health Plan Member Rights and Responsibilities & Kaiser Foundation Hospital Patient Rights and Responsibilities

- The facility reasonably determines that the presence of a particular visitor would endanger the health and safety of a patient, a member of the health facility staff, or other visitor to the health facility, or would significantly disrupt the operations of the facility.
- The patient has indicated to the health facility staff that the patient no longer wants the person to visit

b. Have the patient's wishes considered for purposes of determining who may visit if the patient lacks decision making capacity and to have the method of that consideration disclosed in the hospital policy on visitation. At a minimum, the hospital shall include any person living in the household.

c. Note: The above information on visitors may not be construed to prohibit Kaiser Permanente from otherwise establishing reasonable restrictions upon visitation, including restrictions upon the hours of visitation and number of visitors.

16. A procedure shall be established whereby patient complaints are forwarded to the hospital administration for appropriate response.
17. All hospital personnel shall observe these patient's rights.

Patients have the responsibility to:

1. To provide, to the best of the patient's knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to the patient's health. The patient has the responsibility to report unexpected changes in the patient's condition to the responsible practitioner. A patient is responsible for making it known whether the patient clearly comprehends a contemplated course of action and what is expected of the patient.
2. To follow the treatment plan recommended by the practitioner primarily responsible for the patient's care. This may include following the instructions of nurses and allied health care personnel as they carry out the coordinated plan of care and implement the responsible practitioner's orders, and as they enforce the applicable hospital rules and regulations. The patient is responsible for keeping appointments and when s/he is unable to do so for any reason, for notifying the responsible practitioner or the hospital.
3. To be responsible for the patients actions if the patient refuse(s) treatment or does not follow the practitioner's instructions.
4. To assure that the financial obligations of the patient health care are fulfilled as promptly as possible.
5. To follow Kaiser Foundation Hospital rules and regulations affecting patient care and conduct
6. To be considerate of the rights of other patients and hospital personnel, and for assisting in the control of noise, smoking and the number of visitors. The patient is responsible for being respectful of the property of other persons and of Kaiser Foundation Hospital.

Patient complaints may be forwarded to the hospital administration for appropriate response as follows:

- Questions or concerns may be directed to the Patient Relations Office

Employee Signature:_____NUID:_____Date:_____

KAISER PERMANENTE
HEALTHCONNECT

CONFIDENTIALTY AND NON-DISCLOSURE AGREEMENT

This CONFIDENTIALTY AND NON-DISCLOSURE AGREEMENT (the Agreement) is made between Kaiser Foundation Hospitals, d/b/a Kaiser Permanente (Kaiser Permanente) and the undersigned student nurse (you). This Agreement applies to your use of Kaiser Permanente's electronic medical record system, KP HealthConnect™, and related training materials to carry out your obligations and duties at your assigned Kaiser Permanente Medical Center. KP HealthConnect™ is a Kaiser Permanente trademark.

1. KP HealthConnect™ contains confidential information and proprietary materials owned by Kaiser Permanente and its licensors, such as Epic Systems Corp. The information and materials available in KP HealthConnect™ do not belong to you.

2. You must not print, transmit, download, transfer or make copies of any information, software or screen shots in this training.

3. You must protect the confidentiality of information in KP HealthConnect™ as required by State and Federal law.

4. You must use the KP HealthConnect™ user account assigned to you only if and when you need the information in KP HealthConnect™ to perform your work in the ordinary course of your assignment in providing services to Kaiser Permanente members and patients. You must not use KP HealthConnect™ user account for any personal or other purpose.

5. You must safeguard and keep your KP HealthConnect™ user ID and password secret. Sharing KP HealthConnect™ user ID and password with any other person, including co-workers or supervisors, is strictly prohibited. You must not use any other person's user ID and password to access any Kaiser Permanente system.

6. Kaiser Permanente may monitor your use of KP HealthConnect™ and your KP HealthConnect™ user account. You are personally accountable for any actions taken using the KP HealthConnect™ user ID issued to you.

7. You cannot share or exchange any confidential information with other personnel working at your hospital or facility unless it is required for you to perform your work. If any such sharing or exchange is required, you must follow the correct department procedure and the instructions of your supervisor/ chief of service (such as shredding confidential papers).

8. If you receive a request or demand from any person or organization other than Kaiser Permanente for confidential information or access to KP HealthConnect™, you must promptly notify your supervisor and Kaiser Permanente.

9. Your failure to comply with these obligations may result in the revocation of your KP HealthConnect™ user account and other actions by your employer or Kaiser Permanente.

10. On termination of your placement with Kaiser Permanente, you must return to Kaiser Permanente all copies of documents containing Kaiser Permanente's confidential information in your possession or control.

I UNDERSTAND AND AGREE TO COMPLY WITH THE TERMS STATED IN THIS CONFIDENTIALTY AND NON-DISCLOSURE AGREEMENT.

Print Name Sign Name Today's date

GUIDELINES FOR STANDARD/UNIVERSAL PRECAUTIONS AND PROTECTION AGAINST EXPOSURE TO BLOODBORNE PATHOGENS IN HEALTHCARE SETTINGS

These guidelines apply to ALL employees and physicians in the hospitals, medical office buildings, regional laboratories and other regional services of the Kaiser Permanent Medical Care Program. Additional details are available in your facility's Bloodborne Pathogen Exposure Control Plan. Ask your manager where it is located.

The Kaiser Permanente Medical Care Program mandates the use of Standard/Universal blood and body fluid/substance precautions for all patients and employees as recommended by California and Federal OSHA, the American Hospital Association and the Centers for Disease Control and Prevention (CDC). These guidelines are mandated to protect patients, employees and physicians from the occupational transmission of bloodborne infections, such as Human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV), and Hepatitis C Virus (HCV). Standard/Universal precautions must be strictly followed whenever there is the possibility of contact with blood or other potentially infectious material (OPIM) from any patient regardless of diagnosis. Failure to comply with Standard/Universal precaution practices will result in disciplinary action. OPIM are defined as: semen, vaginal secretions, cerebrospinal fluid, peritoneal fluid, amniotic fluid, synovial fluid, pleural fluid, pericardial fluid, saliva in dental procedures, any body fluid that is visibly contaminated with blood and all body fluids in situations where it is difficult or impossible to differentiate between blood and body fluids.

STANDARD/UNIVERSAL PRECAUTIONS

1. Blood and/or OPIM must be handled in a manner that minimizes splashing, spraying, splattering, and generation of droplets. The use of personal protective equipment (PPE) i.e. gloves, gown, eye shields, masks etc., is required to reduce the risk of occupational exposure. In addition to the use of PPE hand hygiene is required at the start of the work shift, and between dirty and clean procedures on the same patient. Hand hygiene is also required after: contact with equipment or environment that may be contaminated, using the restroom, eating, drinking, smoking, and applying cosmetics. It is required as well before and after: contact with patients and specimens, wearing gloves or other PPE, contact with mucous membranes, and preparing food. Hand hygiene may be accomplished with either waterless degermer or soap and water washing.

2. Gloves are required when anticipated hand exposure to blood and/or OPIM is anticipated. Examples include: venous access procedures (e.g. phlebotomy, IV starts), specimen collection, open wound contact and when handling or touching contaminated items or surfaces.

3. PPE such as gowns and disposable plastic aprons are required during procedures when splashing with blood and/or OPIM is anticipated. Scrubs are NOT PPE.

4. PPE such as masks, face shields, ventilation devices and protective eye wear are required during procedures when splashing, spraying, splatter or droplets of blood and OPIM to the eyes, nose or mouth is anticipated. Eyeglasses are NOT PPE.

5. N-95 NIOSH approved TB respirator masks are required for protection against tuberculosis. Fit testing must be done prior to use of the N-95 mask. Regular masks are required for protection against other airborne transmitted diseases such as chickenpox.

6. Used syringes and disposable sharps must be disposed of immediately at point of use in puncture resistant containers. Do not overfill the containers. Needles should not be recapped or manipulated in any way. If needles must be recapped, a one-hand scooping technique or recapping device must be used. Kaiser has standard sharps safety devices available, which must be used. The safety feature on sharps safety devices must be activated. Education regarding sharps safety devices is required before use.

7. Laboratory specimens must be processed and handled in a safe manner with gloves and placed into leak proof containers labeled with biohazard symbol when required.

8. Emergency resuscitation equipment such as ambubags, mouthpieces, pocket masks, and ventilation devices are required in resuscitation situations.

9. Hepatitis B vaccination is strongly recommended for all employees who have the potential for occupational exposure to blood and OPIM. This is administered in a series of three injections. It is highly effective and safe, and is offered free of charge to all employees.

EMPLOYEE HEALTH

Exposure to blood and/or OPIM via needlesticks, other sharps injury, mucous membranes or non-intact skin requires:

- immediate and thorough washing of the affected area,
- contacting your Manager/designee,
- seeking immediate medical evaluation, and
- contacting Employee Health for documentation of the exposure incident on the Sharps Log.

Signature: _____ Date: _____

Printed name: _____ SS#: _____

96373 (Revised 6-92, 01-03)

GSAA ACCESS-IDENTIFICATION BADGE APPLICATION

The Manager of the individual for whom this photo/access badge is being requested must indicate the access privileges (if any) and must sign his/her signature at the bottom.

PLEASE PRINT

BADGE TYPE

☒ PHOTO ☒ ACCESS ☐ Other: _____

PRIMARY LOCATION *(OF EMPLOYEE)*

☐ FREMONT	☒ SAN LEANDRO	☐ SLEEPY HOLLOW	☐ UC LANDING	☐ UC MOB

EMPLOYEE

Last Name	First Name	Middle Initial	NUID

Title	Credential(s)	Department

MANAGER / DIRECTOR

Last	First	Phone
Villasenor	**Toni**	**x 45134**

SITE ACCESS REQUESTED

☐ FREMONT ☒ SLMC ☐ KPPACC ☐ SLEEPY HOLLOW ☐ UC LANDING ☐ UC MOB

AREA ACCESS REQUESTED

☐ ADMIN	☐ BASEMENT	☐ CCU	☐ CLINTECH
☐ CUP (Engineering)	☐ EMERGENCY DEPT	☐ GENERAL	☐ ICU
☐ LAB/PATH/MORGUE	☐ MATERIALS	☒ MED/PYXIS	☒ MOM/BABY
☒ MCH, L&D, POST-PARTUM	☐ NUTRITION	☐ NICU	☐ OR/PACU
☐ SAFE RM	☐ SLEEP RM	☒ Full Green Card	

☐ I understand that the photo/access badge is the property of Kaiser Permanente. It is my responsibility to return the badge to the local security department upon my transfer or termination.

☐ I understand the photo/access badge is to be worn on my upper torso with my picture and full name visible. I must not pierce or otherwise deface the photo/access badge. The photo/access badge must be displayed at all times while upon Kaiser Permanente property.

Employee Signature: _____ Date: _____

Manager / Director Signature: _____ Date: _____

Manager of Specific Location: _____ Date: _____

Security Services Signature: _____ Date: _____

Security Only

ID Issued: ☐ Yes ☐ No

Access Issued: ☐ Yes ☐ No

Badge No: _____

Parking Tag: _____

SEXUAL HARASSMENT INCLUDES MANY FORMS OF OFFENSIVE BEHAVIORS

BEHAVIORS THAT MAY BE SEXUAL HARASSMENT:

1. *Unwanted sexual advances*
2. *Offering employment benefits in exchange for sexual favors*
3. *Leering; gestures; or displaying sexually suggestive objects, pictures, cartoons, or posters*
4. *Derogatory comments, epithets, slurs, or jokes*
5. *Graphic comments, sexually degrading words, or suggestive or obscene messages or invitations*
6. *Physical touching or assault, as well as impeding or blocking movements*

Actual or threatened retaliation for rejecting advances or complaining about harassment is also unlawful.

Employees or job applicants who believe that they have been sexually harassed or retaliated against may file a complaint of discrimination with DFEH within one year of the last act of harassment or retaliation. DFEH serves as a neutral fact-finder and attempts to help the parties voluntarily resolve disputes. If DFEH finds sufficient evidence to establish that discrimination occurred and settlement efforts fail, the Department may file a civil complaint in state or federal court to address the causes of the discrimination and on behalf of the complaining party. DFEH may seek court orders changing the employer's policies and practices, punitive damages, and attorney's fees and costs if it prevails in litigation. Employees can also pursue the matter through a private lawsuit in civil court after a complaint has been filed with DFEH and a Right-to-Sue Notice has been issued.

THE MISSION OF THE DEPARTMENT OF FAIR EMPLOYMENT AND HOUSING IS TO PROTECT THE PEOPLE OF CALIFORNIA FROM UNLAWFUL DISCRIMINATION IN EMPLOYMENT, HOUSING AND PUBLIC ACCOMMODATIONS, AND FROM THE PERPETRATION OF ACTS OF HATE VIOLENCE AND HUMAN TRAFFICKING.

FOR MORE INFORMATION

Department of Fair Employment and Housing
Toll Free: (800) 884-1684
TTY: (800) 700-2320
Online: www.dfeh.ca.gov

Also find us on:

If you have a disability that prevents you from submitting a written intake form on-line, by mail, or email, the DFEH can assist you by scribing your intake by phone or, for individuals who are Deaf or Hard of Hearing or have speech disabilities, through the California Relay Service (711), or call us through your VRS at (800) 884-1684 (voice).

To schedule an appointment, contact the Communication Center at (800) 884-1684 (voice or via relay operator 711) or (800) 700-2320 (TTY) or by email at contact.center@dfeh.ca.gov.

The DFEH is committed to providing access to our materials in an alternative format as a reasonable accommodation for people with disabilities when requested.

Contact the DFEH at (800) 884-1684 (voice or via relay operator 711), TTY (800) 700-2320, or contact.center@dfeh.ca.gov to discuss your preferred format to access our materials or webpages.

DFEH-185-ENG / December 2018

SEXUAL HARASSMENT

THE FACTS

Sexual harassment is a form of discrimination based on sex/gender (including pregnancy, childbirth, or related medical conditions), gender identity, gender expression, or sexual orientation. Individuals of any gender can be the target of sexual harassment. Unlawful sexual harassment does not have to be motivated by sexual desire. Sexual harassment may involve harassment of a person of the same gender as the harasser, regardless of either person's sexual orientation or gender identity.

THERE ARE TWO TYPES OF SEXUAL HARASSMENT

1. *"Quid pro quo"* (Latin for "this for that") sexual harassment is when someone conditions a job, promotion, or other work benefit on your submission to sexual advances or other conduct based on sex.
2. *"Hostile work environment"* sexual harassment occurs when unwelcome comments or conduct based on sex unreasonably interfere with your work performance or create an intimidating, hostile, or offensive work environment. You may experience sexual harassment even if the offensive conduct was not aimed directly at you.

The harassment must be severe or pervasive to be unlawful. That means that it alters the conditions of your employment and creates an abusive work environment. A single act of harassment may be sufficiently severe to be unlawful.

CIVIL REMEDIES:

1. *Damages for emotional distress from each employer or person in violation of the law*
2. *Hiring or reinstatement*
3. *Back pay or promotion*
4. *Changes in the policies or practices of the employer*

EMPLOYER RESPONSIBILITY & LIABILITY

All employers, regardless of the number of employees, are covered by the harassment provisions of California law. Employers are liable for harassment by their supervisors or agents. All harassers, including both supervisory and non-supervisory personnel, may be held personally liable for harassment or for aiding and abetting harassment. The law requires employers to take reasonable steps to prevent harassment. If an employer fails to take such steps, that employer can be held liable for the harassment. In addition, an employer may be liable for the harassment by a non-employee (for example, a client or customer) of an employee, applicant, or person providing services for the employer. An employer will only be liable for this form of harassment if it knew or should have known of the harassment, and failed to take immediate and appropriate corrective action.

Employers have an affirmative duty to take reasonable steps to prevent and promptly correct discriminatory and harassing conduct, and to create a workplace free of harassment.

A program to eliminate sexual harassment from the workplace is not only required by law, but it is the most practical way for an employer to avoid or limit liability if harassment occurs.

ALL EMPLOYERS MUST TAKE THE FOLLOWING ACTIONS TO PREVENT HARASSMENT AND CORRECT IT WHEN IT OCCURS:

① Distribute copies of this brochure or an alternative writing that complies with Government Code 12950. This pamphlet may be duplicated in any quantity.

② Post a copy of the Department's employment poster entitled "California Law Prohibits Workplace Discrimination and Harassment."

③ Develop a harassment, discrimination, and retaliation prevention policy in accordance with 2 CCR 11023. The policy must:

- Be in writing.
- List all protected groups under the FEHA.
- Indicate that the law prohibits coworkers and third parties, as well as supervisors and managers with whom the employee comes into contact, from engaging in prohibited harassment.
- Create a complaint process that ensures confidentiality to the extent possible; a timely response; an impartial and timely investigation by qualified personnel; documentation and tracking for reasonable progress; appropriate options for remedial actions and resolutions; and timely closures.
- Provide a complaint mechanism that does not require an employee to complain directly to their immediate supervisor. That complaint mechanism must include, but is not limited to including: provisions for direct communication, either orally or in writing, with a designated company representative; and/or a complaint hotline; and/or access to an ombudsperson; and/or identification of DFEH and the United States Equal Employment Opportunity Commission as additional avenues for employees to lodge complaints.
- Instruct supervisors to report any complaints of misconduct to a designated company representative, such as a human resources manager, so that the company can try to resolve the claim internally. Employers with 50 or more employees are required to include this as a topic in mandated sexual harassment prevention training (see 2 CCR 11024).
- Indicate that when the employer receives allegations of misconduct, it will conduct a fair, timely, and thorough investigation that provides all parties appropriate due process and reaches reasonable conclusions based on the evidence collected.
- Make clear that employees shall not be retaliated against as a result of making a complaint or participating in an investigation.

④ Distribute its harassment, discrimination, and retaliation prevention policy by doing one or more of the following:

- Printing the policy and providing a copy to employees with an acknowledgement form for employees to sign and return.
- Sending the policy via email with an acknowledgment return form.
- Posting the current version of the policy on a company intranet with a tracking system to ensure all employees have read and acknowledged receipt of the policy.
- Discussing policies upon hire and/or during a new hire orientation session.
- Using any other method that ensures employees received and understand the policy.

⑤ If the employer's workforce at any facility or establishment contains ten percent or more of persons who speak a language other than English as their spoken language, that employer shall translate the harassment, discrimination, and retaliation policy into every language spoken by at least ten percent of the workforce.

⑥ In addition, employers who do business in California and employ 5 or more part-time or full-time employees must provide at least one hour of training regarding the prevention of sexual harassment, including harassment based on gender identity, gender expression, and sexual orientation, to each non-supervisory employee; and two hours of such training to each supervisory employee. Training must be provided within six months of assumption of employment. Employees must be trained during calendar year 2019, and, after January 1, 2020, training must be provided again every two years. Please see Gov. Code 12950.1 and 2 CCR 11024 for further information.