SCHOOL OF NURSING

Acknowledgement of Essential Functions for Nursing Practice

I have read the Widener University Essential Functions for Nursing Practice. Should I experience any change in my health status, for example, surgery, injury, or pregnancy that could impair my ability to perform these Essential Functions it is my responsibility to see my health care provider. Any limitations must be reported to the office of Disability Services.

Printed Name ____

Student Signature____

Date__________________

Acknowledgement of Health Insurance Portability and Accountability Act (HIPAA) Minimum Necessary Criteria & Responsibility Form

I understand that my role as a member of the workforce and continued role as a member of the workforce is contingent upon compliance with all policies and rules of the Health System. In addition, I understand that I am required to keep confidential patient protected health information. I recognize and acknowledge that during the course of my participation as a member of the workforce, I may become aware of such private and confidential information. I hereby agree to keep this information confidential forever and not to use or disclose it to others, including all members of the Health System's workforce, and its entities and patients and family members, unless there is a need to know and I am otherwise authorized by the Health System, the Health system policies and procedures, the patient (for that patient's specific information) or, where appropriate, as required by law. I understand that I must comply with the Health System's policies and procedures regarding protected health information under HIPAA laws and regulations and I acknowledge that I have been trained in the appropriate uses and disclosures of protected health information as they relate to my specific workforce role.

Printed Name____

Student Signature____

Date__________________