



STATEMENT OF UNDERSTANDING

By my signature below, I affirm that I understand and accept the following terms and conditions which apply to my responsibilities while enrolled in the Externship Program through agreement between *(write college/school & campus)* _____ and Bayhealth Medical Center, Inc.

- A. I will exhibit professional appearance both in manner and dress and will adhere to the standards of dress and behavior specified by Bayhealth Medical Center.
- B. I understand that all information relative to Bayhealth Medical Center business practices and operations are considered confidential and shall not be discussed with any other party without the expressed consent of Bayhealth Medical Center senior management staff.
- C. I shall maintain confidentiality of all patient protected health information in that I shall not discuss such information with anyone other than my instructors, Bayhealth Medical Center staff, and/or health professionals providing care to said patient.
- D. I understand that I shall not receive any financial compensation for participating in this externship program.
- E. I shall commit to an active learning process while enrolled in the externship program. I agree to demonstrate initiative, a positive work ethic, completion of assignments in a timely manner, and to put forth optimal effort relative to all student assignments.
- F. I shall follow the direction of the preceptors to whom I am assigned. I shall not engage in any procedural activity without the expressed consent and directive of my preceptor(s).
- G. During my externship with Bayhealth Medical Center, I agree to comply with all rules, policies, directives, and standards of performance set forth by Bayhealth Medical Center.
- H. I understand that my failure to comply with established rules, policies, directives, and/or standards may subject me to dismissal from the Externship program at Bayhealth Medical Center.

I HEREBY ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THIS STATEMENT OF UNDERSTANDING.

BY: _____
Printed Student Name

Student Signature

Date

WITNESS: _____
(School rep)

Bayhealth Med Ctr

Date