**MEMORANDUM OF UNDERSTANDING FOR**

**SUPERVISED PRACTICE EXPERIENCE ATTACHMENT 2**

## **CONFIDENTIALITY UNDERTAKING FORM FOR SUPERVISED PRACTICE EXPERIENCE**

The collection, use and disclosure of personal information under the custody and control of Fraser Health are governed by British Columbia’s Freedom of Information and Protection of Privacy Act (FOIPPA) and Fraser Health’s policies. Personal information includes the following information: names, addresses, phone numbers, ethnicity, religion, age, marital status, education, employment, and medical and psychiatric history.

I acknowledge and understand as a participant in a supervised practice experience, I may have direct or indirect access to personal or corporate information and agree to ensure the confidentiality of personal information and exercise discretion when discussing Fraser Health business. During my supervised practice experience, I will keep all personal information and Fraser Health corporate information to which I have access confidential, and will only access such information on a “need to know” basis for carrying out my supervised practice experience. Under no circumstances will I permit unauthorized access to, or use of any personal information or Fraser Health corporate information, nor will I access or use any personal information or Fraser Health corporate information.

## I acknowledge that I have read and understand Fraser Health’s applicable policies and procedures, including the Confidentiality and Security of Personal Information Policy, and that I understand the consequences of breaching this Confidentiality and Security of Personal Information Policy and any other applicable Fraser Health policies and procedures.

## I undertake not to alter, copy, interfere with, destroy or remove any information, including personal information, with which I come into contact during my supervised practice experience at Fraser Health.

I also undertake that I will not, either now or after ceasing my supervised practice experience, disclose or otherwise use any personal, patient, and/or sensitive information I learn during my supervised practice experience at Fraser Health.

I acknowledge and agree that the electronic transmission of my signature below will be deemed to constitute my original signature with the same force and effect as if I delivered my original signature.

## I acknowledge that I have read and understand the contents of this Confidentiality Undertaking form and agree to be bound by its terms as evidenced by my signature below.

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**Print Your Full Legal Name**

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**Your Signature**

**Date (dd/mm/yy): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Your complete address, including postal code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your telephone number(s), including area code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FOR LEADER (OR DESIGNATE):**

☐ Ensure that Confidentiality Agreement has been fully completed and signed by SPE Candidate.

☐ Provide copy of the signed Confidentiality Agreement to the SPE Candidate.

☐ Send copies of the signed forms and supporting documentation to Professional Practice (student.placement@fraserhealth.ca).