Protection of Confidential Information

I (Print Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year (ONLY if applicable) \_\_\_\_\_\_\_\_\_

Student of (ONLY if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agree that during my undertaking of Work Experience within Metro South I am aware that I may have access to confidential information in respect to patients, employees or hospital matters, and I agree as a condition of being accepted for such Work Experience, that I will not sue or divulge any information concerning patients, employees or hospital matters to anyone other than authorised personnel of the hospital, and within the Metro South Health only. I am aware that I may face legal action if I improperly disclose or use information concerning patients, employees or hospital matters.

Within the course of your Work Experience you agree that you are bound by the Metro South Health Policies and Procedures.

Signed (Student) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_/\_\_/\_\_

Signed (parent/guardian) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_/\_\_/\_\_

*Parent/Guardian signature only required for High School Work Experience Applicants*

**Note (High School Work Experience Applicants ONLY)**

This form must be signed by both the student and parent / guardian prior to the commencement of Work Experience in Metro South Health and returned to Learning & Development Services ([MSH.WF.Learning@health.qld.gov.au](mailto:MSH.WF.Learning@health.qld.gov.au))

OFFICE USE ONLY

1. Learning and Development, Metro South Health

|  |  |
| --- | --- |
| Name (Please Print) |  |
| Signature |  |
| Date |  |