Modified Duty
Memo of Understanding/Confidentiality Agreement

I, _____, understand that as a condition of employment in a Modified Duty role by: Mecklenburg County EMS Agency

1. I must be in full uniform unless otherwise authorized.
2. I will clock in on time. (My regular scheduled clock-in time, unless otherwise advised). I will clock out for any training, in-service, meeting and/or anytime I leave the building for meals etc. and clock back in for modified duty until my shift is over.
3. I will communicate any and all schedule change requests to the OHN with a 24 hours' notice.
4. I will not work any overtime for any reason, unless I have written authorization from the modified duty sponsor, submitted to the OHN or Risk and Safety.
5. I am subject to attendance points for any attendance policy violations per Policy 2.9.
6. I understand I am responsible to report to the sponsor of the project I am assigned, for the length of the assignment.
7. I will promptly provide all work notes from my treating physician to OHN.
8. I must have a return to full duty note and meet the requirements of the Return to Full Duty Work Form (Attachment 9-1), prior to being placed back into my normal job duties.
9. I am not guaranteed approval into the modified duty program nor am I guaranteed minimum hours while on modified duty.
10. If placed on modified duty by a physician, I must return to work for the remainder of my shift and contact the OHN within 24 hours for possible modified job duties.
11. If I am going to be out/late for any reason I must contact the Operations Assistant (OA) at 704-943-6226 and the OHN at 704-943-6100. Any approved time off will require the use of benefit time.

I shall, neither during nor after the period of employment, including while on Modified Duty or within an Administrative capacity, except in the proper course of my duties or as permitted by Mecklenburg EMS Agency, known as the Agency, or as required by law, divulge to any person any confidential information concerning:

Confidential Patient Care Information

- Records compiled or maintained by the Agency in connection with the dispatch, response, treatment or transport of individual patients, including, but not limited to, patient care reports, CMED records, 911 tapes, recorded radio traffic, and other patient information collected and maintained by the Agency and its First Responders
- Records compiled by the Agency in connection with the statewide trauma system
- Other records compiled or maintained by the Agency that contain personal information relating to a patient's physical or mental condition, medical history, medical treatment and/or patient identifiable data.

Modified Duty
Memo of Understanding/Confidentiality Agreement

Confidential Patient Financial Records

- Personal financial records compiled or maintained by the Agency in connection with admission, treatment and discharge of individual patients, including, but not limited to patient charges, patient accounts and patient credit histories.

Confidential Employee and Business Information

- The Agency prohibits release of information by unauthorized personnel concerning patients and Agency employees including health information, driving records, background checks, financial records, and other such information obtained by the Agency's records which if disclosed would constitute unwarranted invasion of privacy.

I understand and acknowledge that:

1. I will adhere to the conditions of employment in a Modified Duty role.
2. I will abide by all Agency Policies, Standards of Behavior and Code of Ethics to include the Agency's HIPAA, Harassment and Corporate Compliance policies.
3. I shall respect and maintain the confidentiality of all discussions, deliberations, patient care records and any other information generated in connection with individual patient care, risk and safety management, and/or peer review activities.
4. It is my legal and ethical responsibility to protect the privacy, confidentiality and security of all medical records, proprietary information and other confidential information relating to the Agency and its affiliates, including business, employment and medical information relating to our patients and employees.
5. I further undertake to inform my supervisor immediately if I become aware of any breach of privacy or security relating to the information I access in the course of my duties.
6. In the event of a breach or threatened breach of the Confidentiality Agreement, I acknowledge that the Agency may, as applicable and as it deems appropriate, pursue disciplinary action up to and including termination from the Agency.

Signature: _____

Printed Name: _____

Current Supervisor: _____

Employee ID: _____

Date: _____