

# Enrollment Agreement



Dear Prospective Students:

Thank you for your interest in Health Professionals Institute. At the Health Professionals Institute, all current programs including Medical Assistant, Phlebotomy Technician, Electrocardiogram Technician, Nursing Assistant Certified, Home Care Aide, Medical Assistant to Nursing Assistant Bridge, Home Care Aide to Nursing Assistant Bridge, and Medication Assistant Endorsement are approved by the Workforce Training and Education Coordinating Board's State Approving Agency (WTECB/SAA) for enrollment of those eligible to receive benefits under Title 38 and Title 10, USC.

We pride ourselves on developing and empowering the next generation of health care professionals with the highest quality training and educational experience possible.

The enclosed **enrollment agreement** is certified as true and correct for content and policy, including the signature of certifying official below.

Sincerely,

Madhuri Chandra

Administrator

33305 1<sup>st</sup> Way South, B-100

Federal Way, WA 98003

Phone :(253) 252-3956

Fax: (253) 719-8043

Cell: (206) 304-2229

[info@healthprofessionalsinstitute.com](mailto:info@healthprofessionalsinstitute.com)

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[www.healthprofessionalsinstitute.com](http://www.healthprofessionalsinstitute.com)

**Enrollment Agreement**

**Circle all that apply:** Medical Assistant, Phlebotomy Technician, Electrocardiogram Technician, Nursing Assistant, Home Care Aide, Medical Assistant to Nursing Assistant Bridge, Home Care Aide to Nursing Assistant Bridge, Medication Assistant Certified Program

**This enrollment agreement is between the above-named school and:**

**Student Full Name:** \_\_\_\_\_

**Telephone #:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_

**State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Start date:** \_\_\_\_\_ **Completion date:** \_\_\_\_\_

The school agrees to provide the following training: \_\_\_\_\_  
(Course or program title)

Total hours are listed for each program. (Check all that apply)

	Course	Time Period	Classroom Time	Laboratory	Externship	Total Hours
1	Medical Assistant Program	9 months	352 hours	248 hours	200 hours	800 hours
2	Phlebotomy Technician Program	3 months	70 hours	70 hours	160 hours	300 hours
3	Electrocardiogram Technician Program	6 weeks	105 hours	38 hours	40 hours	183 hours
4	Nursing Assistant Certified Program	3 weeks	46 hours	16 hours	56 hours	118 hours
5	Home Care Aide Program	2 - 3 weeks	63 hours	12 hours	---	75 hours
6	Medication Assistant Endorsement Program	3 - 4 weeks	50 hours	10 hours	40 hours	100 hours
7	Medical Assistant to Nursing Assistant Bridge Program	3 days	8 hours	8 hours	8 hours	24 hours
8	Home Care Aide to Nursing Assistant Bridge Program	3 days	8 hours	8 hours	8 hours	24 hours

Total costs are listed for each program. (Check all that apply)

Course	Registration Fee	Entrance Exam	Tuition	Book (+tax)
Medical Assistant Program	\$100	\$25	\$17,000	\$250
Phlebotomy Technician Program	\$100	\$25	\$3500	\$200
Electrocardiogram Technician Program	\$100	\$25	\$3500	\$180
Medication Assistant Endorsement Program	\$100	\$25	\$3500	\$50
Nursing Assistant Certified Program	\$60	\$25	\$750	\$50
Home Care Aide Program	\$50	\$25	\$750	\$50
Medical Assistant to Nursing Assistant Bridge Program	\$50	\$25	\$750	\$50
Home Care Aide to Nursing Assistant Bridge Program	\$50	\$25	\$750	\$50

**METHOD OF PAYMENT:**

I agree that the payment of program costs will be satisfied by (check all that apply):

- Cash
- Credit Card
- Scholarship
- (WRT) Worker Retraining Program
- VA- GI Bill
- Third Party (e.g. VA, Voc. Rehab., L & I, Employer): \_\_\_\_\_

PAYMENT	AMOUNT DUE	PAYMENT TYPE	PAYMENT DATE	AMOUNT PAID
<b>Registration Fee</b>				
<b>Tuition</b>				
<b>Book</b>				
<b>Entrance Exam</b>				
<b>Criminal History</b>				
<b>TOTAL PAYMENTS</b>				

**Terms and Conditions:** To hold a place in a class, the student must pay \$100 for the registration fee and \$25 for the entrance exam upon registration.

**Application**

**Directions: Check one in each category.**

<p>Education:</p> <p><input type="checkbox"/> 11. Less than high school graduate</p> <p><input type="checkbox"/> 12. GED</p> <p><input type="checkbox"/> 13. High school graduate</p> <p><input type="checkbox"/> 14. Some post-high school, no degree/ certificate</p> <p><input type="checkbox"/> 15. Certificate (less than 2 years completed)</p> <p><input type="checkbox"/> 16. Associates Degree</p> <p><input type="checkbox"/> 17. Bachelor's Degree or higher</p> <p><input type="checkbox"/> 90. Other</p> <p><input type="checkbox"/> 99. Prior education Unknown</p>	<p>Race:</p> <p><input type="checkbox"/> 1. White/Caucasian</p> <p><input type="checkbox"/> 2. Black/African American</p> <p><input type="checkbox"/> 4. American Indian or Alaskan Indian</p> <p><input type="checkbox"/> 5. Asian</p> <p><input type="checkbox"/> 6. Hawaiian Native or Pacific Islander</p> <p><input type="checkbox"/> 7. multi-racial</p> <p><input type="checkbox"/> 8. Other</p> <p><input type="checkbox"/> 9. Unknown or wish not to answer</p>
<p>Disability:</p> <p><input type="checkbox"/> 1. Yes</p> <p><input type="checkbox"/> 2. No</p> <p><input type="checkbox"/> Blank/Unknown/Wish not to answer.</p> <p>Veterans:</p> <p><input type="checkbox"/> 1. Yes</p> <p><input type="checkbox"/> 2. No</p> <p><input type="checkbox"/> Blank/Unknown/Wish not to answer</p> <p>Employment:</p> <p><input type="checkbox"/> Not currently Employed.</p> <p><input type="checkbox"/> Currently Employed with: _____</p> <p>_____</p>	<p>Hispanic</p> <p><input type="checkbox"/> 1. Hispanic</p> <p><input type="checkbox"/> 2. Non-Hispanic</p> <p><input type="checkbox"/> Blank/Unknown/Wish not to answer</p>
<p>Employer Name: _____</p> <p>Employer Address: _____</p> <p>Employer Phone Number: _____</p> <p>In Case of Emergency:</p> <p>Name: _____ Phone: _____</p> <p>Name: _____ Phone: _____</p> <p>Allergies (in case of an emergency): _____</p> <p>How were you referred to our institution? _____</p>	



**Emergency Contact Information**

This is a confidential form between you and your instructors. We would like to know the following information for your health and safety.

**Emergency Contact**

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Relationship: \_\_\_\_\_

Health Issues such as allergies, asthma, migraine headaches, seizures disorder, etc. Please note that this does NOT restrict you from participating in this class or being a nursing assistant.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I would like a passcode OR the last four digits of your social security number that only you and I will know. When we post-test scores or you will call us. We will use this as the identification number for verification.

Passcode Number: \_\_\_\_\_

## **AGREEMENT NOTICE:**

This agreement will be binding only when it has been fully completed, signed, and dated by the student and an authorized representative of the school before the time instruction begins.

### **Changes to the Agreement Notice**

Any changes in the agreement will not be binding on either the student or the school unless such changes are acknowledged in writing by an authorized representative of the school and by the student, or the student's parent or guardian if he/she is a minor.

### **Refund Policy**

1. The school must refund all monies paid if the applicant is not accepted. This includes instances where starting a class is canceled by the school.
2. The school must refund all monies paid if the applicant cancels the class within five business days of signing the contract but before the class starts (excluding Saturday, Sundays, and holidays).
3. The school may retain an established registration fee equal to ten percent of the total tuition cost, or one hundred dollars, whichever is less if the applicant cancels past the fifth business day after signing the contract or making an initial payment. A registration fee is any fee charged by a school to process student applications and establish a student record system.
4. **The school will only refund the full tuition payment but not the fees and costs** paid for registration, entrance exam, and TB test. Costs for uniforms, books, and other materials purchased for the class are only refundable **within 14 days before the start of the program.**

When calculating refunds, the official date of a student's termination is the last day of recorded attendance:

When the school receives notice of the student's intention to discontinue the training program; or,

- When the student is terminated for a violation of a published school policy which provides for termination; or,
- When a student, without notice, fails to attend classes for thirty calendar days.

All refunds must be paid within thirty calendar days of the student's official termination date.

5. If training is terminated after the student enters classes, the school may retain the registration fee established under (3) of this subsection, plus a percentage of the total tuition as described in the following table:

<b>If the student completes this amount of training:</b>	<b>School may keep this percentage of tuition:</b>
One week or up to 10% whichever is less	10%
More than one week (or 10%), whichever is less, but less than 25%	25%
25% to 50%	50%
More than 50%	100%



## **Payment Plan**

Payment plans are available.

## **Worker Retraining Program**

The worker Retraining program is based on eligibility.

## **Veterans Benefits**

Selected programs of study at Health Professionals Institute are approved by the Workforce Training and Education Coordinating Board's State Approving Agency (WTECB/SAA) for enrollment of those eligible to receive benefits under Title 38 and Title 10, USC. Health Professionals Institute does not and will not provide any commission, bonus, or other incentive payment based directly or indirectly on success in securing enrollment or financial aid to any persons or entities engaged in any student recruiting or admissions activities or in making decisions regarding the award of student financial assistance. Health Professionals Institute limits student enrollment to 85% veteran enrollment per cohort. If a veteran wishes to enroll in a class that has already reached the 85% cap, he or she may do that but will not be eligible for VA funding. Chapter 35 and 31 students may still enroll even if 85% has been realized. The VA does not pay for Application or Registration fees or any other fees associated with the admission process as these fees are not considered in pursuit of the program. VA also does not pay for any non-mandatory charges. VA only pays for mandatory fees charged for the pursuit of the program (and charged to all students). Some fees may appear to be mandatory however the VA could rule that they are not.

## **VA Prorate Refund Policy**

Health Professionals Institute agrees that if a veteran student fails to enter the course, withdraws, or is discontinued at any time before completion of the course, the unused portion of paid tuition, fees, and other charges will be refunded or the debt for such tuition, fees, and other charges will be canceled on a prorated basis, as follows:

**(1) Registration fee.** An established registration fee in an amount not to exceed \$10 need not be subject to proration. Where the established registration fee is more than \$10, the amount over \$10 will be subject to proration.

**(2) Breakage fee.** Where Health Professionals Institute has a breakage fee, it may provide for the retention of only the exact amount of the breakage, with the remaining part, if any, to be refunded.

**(3) Consumable instructional supplies.** Where Health Professionals Institute makes a separate charge for consumable instructional supplies, as distinguished from laboratory fees, the exact amount of the charges for supplies consumed may be retained but any remaining part must be refunded.

**(4) Books, supplies, and equipment.**

a. Health Professionals Institute will make a refund in full for the amount of the charge for unissued books, supplies and equipment when:

- Health Professionals Institute furnishes the books, supplies and equipment,
- Health Professionals Institute includes their cost in the total charge payable to the school for the course,
- The veteran or eligible person withdraws or is discontinued before completing the course.

b. The veteran or eligible person may dispose of issued items at his or her discretion even if they were included in the total charges payable to the school for the course.

**(5) Tuition and other charges.** Where Health Professionals Institute either has or adopts an established policy for the refund of the unused portion of tuition, fees, and other charges subject to proration, which is more favorable to the veteran or eligible person than the approximate pro rata basis as provided in this paragraph, such established policy will be applicable. Otherwise, Health Professionals Institute may charge a sum which does not vary more than 10 percent from the exact pro rata portion of such tuition, fees, and other charges that the length of the completed portion of the course bears to its total length. The exact proration will be determined on the ratio of the number of days of instruction completed by the student to the total number of instructional days in the course.

**(6) Prompt refund.** In the event that the veteran, spouse, surviving spouse or child fails to enter the course, or withdraws, or is discontinued there from at any time prior to completion of the course, the unused portion of the tuition, fees and other charges paid by the individual shall be refunded promptly. Any institution which fails to forward any refund due within 40 days after such a change in status, shall be deemed, prima facie, to have failed to make a prompt refund, as required by this subparagraph.

### **Notice to Buyer**

Do not sign this agreement before you read it or if it contains any blank spaces. This is a legal document. All pages of this contract are binding. Read both sides of all pages before signing. You are entitled to an exact copy of the agreement, school catalog, and any other papers you may sign and any other papers you may sign and are required to sign a statement acknowledging receipt of those.

### **Cancellation of Contract**

If the student has not started the program, he/she may cancel the program agreement by submitting a written notice of such cancellation to the school at its address shown on the contract. **The notice of cancellation shall be submitted no later than midnight of the fifth day** (excluding Saturdays, Sundays and legal Holidays) following your signing of this contract and agreement. The written notice may be personally delivered to the school within that time. In the event of dispute over timely notice, the burden of proof of service rests on the sender.

**Unfair Business Practices**

It is an unfair business practice for the school to sell, discount, or otherwise transfer this contract or promissory note without the signed consent of the student or his/her financial sponsors if he/she is a minor, and a written statement notifying all parties that the cancellation and refund policy continues to apply.

**CERTIFICATION**

I certify that I have read and understand the cancellation and refund policy and the complaint procedure: I received a copy of the school catalog and I am entitled to an exact copy of this enrollment agreement, school catalog, and any other papers I sign.

**Student**

Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Parent or Guardian** (if the student is under 18 years of age):

Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Authorized School Representative:**

**As the authorized representative of the school, I hereby agree to the conditions set forth herein.**

Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

This school is licensed under Chapter 28C.10 RCW. Inquiries or complaints regarding this private vocational school may be made to: Workforce Training and Education Coordinating Board 128 – 10<sup>th</sup> Avenue SW Olympia, Washington 98501. Phone: (360)709- 4600 Email: [pvs@wtb.wa.gov](mailto:pvs@wtb.wa.gov) Web: [wtb.wa.gov](http://wtb.wa.gov)

## Acknowledgement by Enrollee and by School

**NOTICE OF FINANCIAL OBLIGATION**

Washington State law requires the following information to be supplied to each student enrolling in a private vocational school licensed under RCW 28C.10. One copy of this notice bearing the original signatures must be attached by the school as an addendum to that individual’s enrollment agreement and a copy must be provided to the enrollee by the school.

**ACKNOWLEDGEMENT BY ENROLLEE**

I understand and accept that any contract entered into with the above named, contains legally binding obligations.

I understand and accept that repayment obligations will be placed on me by any loans or other financial arrangements I enter into to pay for my training.

I understand that any enrollment contract I enter into will not be binding or take effect for at least (5) five business days, excluding Saturdays, Sundays, and legal holidays, following the last date such a contract is signed by the school and myself, provided I have not entered classes sooner.

**STUDENT SIGNATURE**

Name: \_\_\_\_\_

Signed: \_\_\_\_\_

Dated this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_

**ACKNOWLEDGEMENT BY SCHOOL**

Prior to being enrolled in this school, the training applicant whose name and signature appear below has been made aware of the legal responsibilities and obligations he/she takes on by entering into a contract for training. Those discussions included cautions by the school about acquiring an excessive debt burden that might become difficult to repay given employment opportunities and average staffing salaries in his/her chosen occupation.

**Health Professionals Institute  
EMPLOYEE/PERSONNEL SIGNATURE**

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Signed: \_\_\_\_\_

Dated this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_

**HOW TO FILE A COMPLAINT**

Washington law requires private vocational schools to inform students how to file a complaint. By signing this form you acknowledge this process has been explained to you. Below are the next steps the school must take in discussing this policy with you, along with information about the complaint process.

**DISCUSSION ABOUT COMPLAINT POLICY REQUIRED**

First, a school representative must discuss the school’s complaint policy with you. Following this discussion, you will be provided with this attachment to sign. After you sign this form, the school will give you a copy for your personal records. The school will also keep a copy on file.

**ACKNOWLEDGMENT OF COMPLAINT PROCESS BY STUDENT**

1. The school has described the grievance and/or complaint policy to me.
2. I understand that the policy can also be found in the school catalog.
3. I know I should first try to resolve a complaint or concern with my instructor or school administrator.
4. I understand nothing prevents me from contacting the Workforce Board at 360-709-4600 at any time with a concern or complaint, and complaint forms are: [http://wtb.wa.gov/PCS\\_Complaints.asp](http://wtb.wa.gov/PCS_Complaints.asp).
5. I understand that I have one year to file a complaint from my last date of attendance.
6. I further understand that in the event of a school closure, I have 60 days to file a complaint.
7. I also understand that complaints are public records.
8. Finally, I acknowledge that details about the complaint process, my rights, and any restrictions on the time I have to file a complaint can be found at [http://wtb.wa.gov/PCS\\_Complaints.asp](http://wtb.wa.gov/PCS_Complaints.asp)

Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_, 20 \_\_

**ACKNOWLEDGMENT BY SCHOOL**

Prior to being enrolled in this school, the applicant, whose name and signature appear above, has been made aware of the school’s complaint policy.

Name: \_\_\_\_\_ Simate: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_, 20

**Criminal History Disclosure Statement**

According to Washington State licensing law, Medical Assistant, Phlebotomy Technician, Electrocardiogram Technician, Nursing Assistant, Home Care Aide, Medical Assistant to Nursing Assistant Bridge, Home Care Aide to Nursing Assistant Bridge and Medication Assistant Certified Programs are required by RCW 43.43.834 to obtain a disclosure statement for all employees, volunteers, students or other individuals providing direct care to children and vulnerable adults as defined in RCW 43.43.842.

- I. Have you ever been convicted of any of the following crimes against children or other persons?

**Please check Y for Yes and N for No**

	Y	N		Y	N		Y	N
Aggravated Murder			Arson 1st degree			Assault 1st degree		
Assault 2nd degree			Assault 3rd degree			Simple assault 4th degree		
Assault of child 1st degree			Assault of child 2nd degree			Assault of child 3rd degree		
Burglary 1st degree			Child abandonment			Child abuse/neglect-RCW 26.44.020		
Child buying or selling			Child molestation 1st degree			Child molestation 2nd degree		
Child molestation 3rd degree			Communication w/minor for immoral purposes			Criminal abandonment		
Criminal mistreatment 1st degree			Criminal mistreatment 2nd degree			Custodial assault		
Custodial interference 1st degree			Custodial interference 2nd degree			Extortion 1st degree		
Extortion 2nd degree			Extortion 3rd degree			Felony indecent exposure		
Forgery			Indecent liberties			Kidnapping 1st degree		
Kidnapping 2nd degree			Manslaughter 1st degree			Manslaughter 2nd degree		
Manslaughter 3rd degree			Murder 1st degree			Murder 2nd degree		
Patronizing a juvenile prostitute			Promoting pornography			Promoting prostitution 1st degree		
Prostitution			Rape 1st degree			Rape 2nd degree		
Rape 3rd degree			Rape of a child 1st degree			Rape of child 2nd degree		
Rape of child 3rd degree			Robbery 1st degree			Robbery 2nd degree		
Selling/distributing erotic material to a minor			Sexual exploitation of minors			Sexual misconduct with a minor 1st degree		
Sexual misconduct with a minor 2nd degree			Theft 1st degree			Theft 2nd degree		
Theft 3rd degree			Unlawful imprisonment			Vehicle homicide (negligent homicide)		
Violation child abuse restraining order								

- II. If your record shows a conviction for the following crimes, and the conviction date (court date) is three to five years before this admission application, you may not be disqualified from school admission:

Three Years (3)	Yes	No	Five Years (5)	Yes	No
Assault 4th degree			Forgery		
Prostitution			Theft 2nd degree		
Theft 3rd degree					

If the answer is “yes” to any of the above, please describe the conviction, the sentence and provide the dates:

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III. The school may disqualify your application if your record shows conviction for the following crimes:

	Yes	No
Manufacture of controlled substances		
Delivery of controlled substances		
Possession with intent to manufacture controlled substances		
Possession with intent to deliver controlled substances		

IV. Pursuant to RCW 43.42.834 have you ever been?

	Yes	No
Convicted of any crime against children or other persons		
Convicted of crimes relating to financial exploitation if the victim was a vulnerable adult		
Convicted to crimes related to drugs as defined in RCW 43.43.830		
Found in any dependency action under RCW 13.34.040 to have sexually assaulted or exploited any minor or to have physically abused any minor		
Found by a court in a domestic relation proceeding under Title 26 RCW to have sexually abused or exploited any minor or to have physically abused any minor		
Found in any disciplinary board final decision to have sexually or physically abused or exploited any minor or developmentally disabled person or to have abused or financially exploited any vulnerable adult		
Found by a court in a protection proceeding under chapter 74.34 RCW to have abused or financially exploited a vulnerable adult		

If the answer is “yes” to any of the above, please describe the conviction and the sentence and provide dates

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UNDER PENALTY OF PERJURY, I certify that the above information is true, correct, and complete. I understand that if I am enrolled, I can be discharged for my misrepresentation or omission in the above statement. I also understand that you will request a criminal background check from the Washington State Patrol to verify the accuracy of the information I have provided. A copy of the Washington State Patrol check will be made available to you upon your request. We may request your fingerprints to obtain from the Washington State Patrol criminal identification system a report of your record of criminal convictions for offenses against persons, civil adjudication of child abuse, and disciplinary board final decisions. If you are enrolled before that report is available, **your enrollment will be conditioned upon the receipt of a satisfactory report.**

Full Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

### **Confidentiality / Security Agreement – Students**

I have received Health Insurance Portability and Accountability Act (HIPAA) training and as such, I understand that while performing my official duties I may have access to protected health information. Protected Health Information (PHI) means individually identifiable health information that is transmitted or maintained in any form or medium. Protected health information is *NOT* open to the public. Special precautions are necessary to protect this type of information from unauthorized access, use, modification, disclosure, or destruction.

### **I agree to protect the following types of information:**

All data elements described as protected health information (HPI) including but not limited to:

- Addresses
- Telephone numbers
- Fax numbers
- Electronic Mail addresses
- Social security numbers
- Medical record numbers
- Birthdate
- Date of death
- Health plan beneficiary numbers
- Account numbers
- Certificate/license numbers
- Vehicle identifiers and serial numbers, including license plate numbers
- Device identifiers and serial numbers
- Full face photographic images and any comparable images
- Client information (such as disability insurance claimants, recipients of public social services, participants of state/federal programs, employers, etc.)
- Information about how automated systems are accessed and operate
- Any other proprietary information.
- Any other unique identifying number characteristic, or code



**I agree to protect HPI by:**

All of the following means including but not limited to:

- Accessing, using or modifying confidential, sensitive, or PHI only to perform my official duties
- Never attempting to access information by using a user identification code or password other than my own
- Never share passwords with anyone or storing passwords in a location accessible to unauthorized persons.
- Never exhibiting or divulging the contents of any record or report except to fulfill a work assignment.
- Never showing, discussing, or disclosing confidential, sensitive, or PHI to or with anyone who does not have the legal authority or the “need to know”
- Storing confidential, sensitive information in a place physically secure from access by unauthorized persons.
- Never removing confidential, sensitive, or HPI from the work area without authorization.
- Disposing of confidential, sensitive, or HPI by utilizing an approved method of destruction, which includes shredding, burning, or certified or witnessed destruction. Never disposing of such information in the wastebaskets or recycle bins.
- Reporting any violation of confidentiality, privacy, or security policies

**Penalties**

Unauthorized access, use, modification, disclosure, or destruction is strictly prohibited. The penalties for unauthorized access, use, modification, disclosure, or destruction may include disciplinary action up to and including termination of course and/or criminal or civil action.

Health Professionals Institute and the facilities (clinical site) reserves the right to monitor and record all network activity including e-mail, with or without notice, and therefore users should have no expectations of privacy in the use of these resources.

*I certify that I have read, understood, and accept the Confidentiality Agreement above.*

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_