

Appendix A

STUDENT PLACEMENT AGREEMENT

**To be completed by Student prior to placement with NORTHWEST TERRITORIES HEALTH AND SOCIAL SERVICES AUTHORITY (“NTHSSA”),
HAY RIVER HEALTH AND SOCIAL SERVICES AUTHORITY (“HRHSSA”),
TŁİCHQ COMMUNITY SERVICES AGENCY (“TCSA”) or GOVERNMENT OF THE NORTHWEST TERRITORIES, DEPARTMENT OF HEALTH AND SOCIAL SERVICES (“DHSS”).**

Student Information	
Legal Name	
Mailing address	
Contact Phone	
Contact Email	

Institution Information	
School/Institution	
Instructor/Coordinator	
Phone	
Email	

Student Program	
Program of Study	
Year of Study	

Placement Information	
Authority of Practicum Placement	
Community	
Placement Dates	Start: _____ End: _____
Placement Supervisor	
Contact	
Email	

The Agreement:

The School and the Northwest Territories Health and Social Services Authorities (NTHSSA, HRHSSA and TCSA) and DHSS have signed an Agreement about the placement program in which you wish to participate.

Prior to starting a placement with the Authority identified above as the “Authority of Practicum Placement”, you are required to read and sign this student placement agreement. This document

describes your responsibilities during your placement and other important information you should know.

Review carefully before signing.

By signing this Agreement, I agree to the following:

1. Placement programs cannot compromise the client/patient care or client service objectives of the Authority. Authority staff are the final authority for all aspects of client/patient care or client service and for the integration of the placement programs into the Authority.
2. The Authority has the right to require me to leave because of my performance or conduct.
3. I am aware of my responsibility to maintain appropriate behaviour while on my placement, particularly concerning patients'/clients' privacy and confidentiality of patients'/clients' records, including my obligation under the Northwest Territories *Health Information Act*, and all other facility related information and matters. All such information is confidential and cannot be communicated, except as outlined in any policy of the Authority. I will not disclose or discuss what I see or hear, nor will I pass on any information from written records concerning any client/patient, except for the purposes of client/patient care. If confidentiality is breached, the penalty may include termination of my placement.

My confidentiality obligation continues indefinitely after the end of my placement. _____ **initial**

4. Intellectual property that I create or contribute to that (i) forms part of any client record; (ii) is owned or developed by or on behalf of the Authority, including any policies, procedures or manuals; or (iii) is developed in relation to any research, trial or project undertaken by or on behalf of the Authority; is owned by the Authority. Written permission of the Authority will be required for any use of this intellectual property outside of my placement.
5. I acknowledge that a client/patient has the right to refuse to be a participant in placement programs. This applies only to students providing medical services.
6. I will be assigned client/patient care or service responsibilities only to the degree commensurate with my level of ability, and optimum learning will be provided without diminishing the quality of client/patient care or service. I will not under-take or perform any task which is outside the scope of the responsibilities specifically assigned to me. If I believe a task is beyond my level of ability or learning, I will immediately inform my supervisor. This applies only to students providing medical services.
7. Prior to commencing a placement and at my own expense, I agree to obtain a criminal record check completed within the past three (3) months, with a vulnerable sector search, and to submit same to the School. I agree that the School will share this information with the Authority. I acknowledge that either the School or the Authority may refuse my access to the student placement program should I have a criminal record of concern. _____ **initial**

8. Prior to commencing a placement, I agree to provide an updated immunization record in accordance with the provisions set out under all GNWT Immunization related Acts, Policies and Procedures including, but not limited to proof of vaccination status. I agree that the School will share this information with the Authority upon request. _____ **initial**
9. The Authority is not responsible for obtaining health or disability insurance coverage for me and it does not have or accept any responsibility for the risk of illness or accidental injury that I may incur at the worksite during this placement or while I am in the Northwest Territories.

I have ensured that I have, or I have verified with my School that my School has arranged for me, insurance coverage that includes Workers' Compensation Board Insurance, or the equivalent, during the entirety of my placement; and travel medical insurance during the entirety of my placement, 24 hours a day, 7 days a week, including coverage:

- (a) for emergency medical, accident, and sickness, including for incidents occurring when not working;
- (b) for medical evacuation, including for incidents occurring when not working; and
- (c) when providing services and/or travelling for other purposes on medical evacuation (medevac) flights, in an amount not less than \$1,000,000.00 per occurrence. _____ **initial**

10. I understand that Authority staff will share information about my performance during the placement with the School.
11. I understand I am expected to comply with the Authority's policies, procedures, rules and by-laws, including the Harassment Free and Respectful Workplace Policy, available at: <https://www.fin.gov.nt.ca/en/resources/harassment-free-and-respectful-workplace-policy>.
12. I consent to the use by the Authority of the personal information provided in this Agreement and any other personal information necessary to undertake the placement program. I consent to the use of my personal information by the Authority should the Authority wish to contact me for future employment opportunities. I may withdraw this consent at any time.

Signed by:

Student

Witness

Date

Print Witness Name

Send to HSSPrograms@gov.nt.ca prior to Placement Start