BUNGOM DISTRICT HOSPITAL

P.O BOX 14 BUNGOMA

LABORATORY DEPARTMENT

SYSTEM PROCEDURE FORM

CONFIDENTIALITY AND NON-DISCLOSURE AGREEMENT

I ………………………………………………………………………hereby declare

(FULL NAMES)

that I fully understand the patients or participants rights to confidentiality with regards to identity and laboratory test results and will adhere to this principle at all times.

I will also not disclose organizational information to anyone outside our operation either during or after my period of employment with Bungoma District Hospital Laboratory or my visit at Bungoma District hospital laboratory.

If lam in breach of this contract, I fully understand that the Bungoma District Hospital reserves the right to take action against me.

Signature ………………………………………………. Date ……………………

Institution…………………………………………………………………………….

Telephone……………………………………………………………………………

Witness Name ………………………………………………………………………

Signature …………………………………………………… Date ……………………