[PRACTICE HEADED PAPER]

**Name of Medical Student:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Student ID number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical School:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Attachment Period:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of GP assigned to:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that **Confidential Information** means all confidential information (including patient information, personal data, know-how, ideas and concepts, financial information and operational processes) and such other proprietary information relating to this Practice (however recorded or preserved), which is disclosed or made available to me whether before or after the date of this agreement (in any form or medium), directly or indirectly.

I acknowledge that this Practice has custody and control of Confidential Information, which it must protect for ethical, legal and proprietary reasons.

In consideration of this Practice agreeing to my attachment during which time certain Confidential Information may be made available to me, I agree to be bound by the following principles of confidentiality:

1. Any Confidential Information which I have accessed or become aware of by virtue of my attachment as medical student to this Practice will be kept confidential both during and after my attachment.
2. I shall only discuss cases seen during my attachment with GPs from this Practice or at recognised teaching sessions organised by the medical school, where it is appropriate to do so. Patient information will be kept anonymous during these discussions. Likewise, if writing about patients for assignments, learning logs etc, I shall preserve the patient’s anonymity by removing any references, information or documentation that might reasonably identify the patient in question.
3. I shall not disclose or remove any Confidential Information from this Practice without the prior written consent of my supervising GP.
4. I shall not access medical records belonging to me, members of my family or those known to me without the prior written consent of my supervising GP.

**Medical Student:**

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

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

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

**Supervising GP:**

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

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

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