University of Medicine and Dentistry of New Jersey

INTERNSHIP CONFIDENTIALITY AGREEMENT

I understand that in the course of my internship experience I may have access to and be involved in the processing of verbal, written, computer generated, computer accessed, filmed, and/or recorded information related to clients, patients, employees, or University business.

I understand that I am required to maintain confidentiality of this direct or indirect information at all times, both during and after my internship experience. I understand that I will not share, discuss, or reveal any of this information with anyone.

I understand any breach of confidentiality may result in disciplinary action, including termination of my internship, or legal action.

I certify by my signature that I acknowledge being informed of the confidentiality policy concerning confidential information and its treatment. I agree to adhere to and uphold the private and privileged information therein.

Intern Name: _____

Signature: _____ Date: ____ / ____ / ____

Witnessed by

Supervisor/Mentor: _____

Signature: _____ Date: ____ / ____ / ____

Revised 3/2011