TENNESSEE DEPARTMENT OF HEALTH

PERSONNEL CONFIDENTIALITY STATEMENT

By signing below, I acknowledge and understand that, as a State employee of the Tennessee Department of Health or as a County, Contract, or Municipal employee working for the Tennessee Department of Health, I am prohibited from releasing to any unauthorized person any medical information which may come to my attention in the course of my duties.

Moreover, I acknowledge and understand that any breach of confidentiality, patient or otherwise, resulting from my written or verbal release of information or records provides grounds for disciplinary action, which may include my immediate termination as an employee of the department.

DRUG-FREE WORKPLACE

I, as a State employee of the Tennessee Department of Health, or as a County, Contract, or Municipal employee working for the Tennessee Department of Health, hereby certify that I have received a copy of the Tennessee Department of Health's policy regarding the maintenance of a drug-free work place. I realize that the unlawful manufacture, distribution, dispensation, possession or use of a controlled substance is prohibited in the workplace or on state property and violation of this policy can subject me to discipline up to and including termination. I realize that as a condition of employment, I must abide by the terms of this policy and will notify the employer of any criminal drug conviction for a violation occurring in the workplace no later than five (5) days after such conviction. I further realize that federal law mandates that the employer communicate this conviction to a federal agency, where appropriate, and I hereby waive any and all claims that may arise for conveying this information to the federal agency. By signing below, I acknowledge that I have agreed to comply with the Drug-Free Workplace Policy of the Tennessee Department of Health.

SEXUAL HARASSMENT ACKNOWLEDGMENT

By signing below, I acknowledge that I have read and agree to comply with the Sexual Harassment Policy of the Tennessee Department of Health.

CONFLICT OF INTEREST POLICY ACKNOWLEDGMENT

By signing below, I acknowledge that I have read and agree to comply with the Conflict of Interest Policy of the Tennessee Department of Health.

_____	_____
Signature	**Supervisor's Signature**
_____	_____
Date	**Date**
_____	
Print Name	
_____	
Social Security Number	

PH-3131 **RDA N/A**