



FLINT

# NO SMOKING POLICY NOTIFICATION AND AGREEMENT

To provide an environment that promotes wellness for patients, visitors, employees, volunteers, and medical staff members, and to recognize the harmful effects associated with smoking, McLaren Flint has adopted a non-smoking policy.

This policy is based on regulations and directives of the Joint Commission on Accreditation of Health Organizations, Michigan Department of Public Health and the Michigan Public Health Code and Michigan State Law (P.A. 315, 1988, Sec. 12604 @ (2)(a).

**Smoking and tobacco use is not permitted in any McLaren owned or leased vehicles, or on property that is owned, leased or under the control of McLaren, including, but not limited to; parking lots, parking ramps, walkways, buildings, and vehicles (Ref. HR Policy-130).**

### Patients and Visitors:

1. Patients and visitors will be informed of the non-smoking status through pre-admission procedures, documents in the admission packet, and signage throughout McLaren Flint’s facilities.
2. Because caregivers are not able to monitor patients when they are outside of the building, patients may not leave the building to smoke while they are hospitalized at McLaren Flint. **Patients who violate this rule and leave the building to smoke do so at their own risk. The hospital is not liable for injuries or harm that may occur as a result of this action. Any damage to hospital equipment will be the patient’s responsibility.**
3. If a patient is observed smoking or requests to smoke, Nursing Management will be notified. If the patient continues to smoke, then the patient’s attending physician will be notified and hospital equipment will be discontinued.

### Patient or Legal Designee Please Read and Sign

I agree to abide by McLaren Flint’s non-smoking policy. While I am a patient at McLaren Flint, I will refrain from smoking. I understand that if I choose to violate this policy, McLaren Flint will notify my attending physician. I understand that I can request nicotine withdrawal medication.

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Patient or Legal Designee

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
PT.

\_\_\_\_\_  
MR.#/RM.

\_\_\_\_\_  
DR.



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