Premier Health

Job Shadow Application
Academic

JOB SHADOW INFORMATION

The Job Shadow Program is an observation only experience in a select department within Premier Health based on availability. The participant will have an opportunity to observe and interact with a healthcare worker as they go about their daily activities. Hands-on patient care isn't part of the job shadow experience and will not be permitted. The purpose of the job shadow experience is to foster an awareness of the skills required for a specific career and to experience healthcare culture. This program was developed to assist college students meet observation experience requirements to gain admittance into an academic program.

Note that the application process includes reviewing a separate document, "Premier Health: Job Shadow Rotation Brochure" and Content Review. You will also need to complete the Content Review document. **Failure to properly complete the forms, return required documentation on time, and have a parent's signature if under 18 years of age, will result in a delay in processing your application.**

GUIDELINES FOR JOB SHADOW

- Participants must fill out all required forms completely including: Job Shadow Application and the Waiver of Liability and Health Form.
- It is required that you have the following:
  - Influenza vaccine in the current season when participating in a job shadow experience from October 1st through March 31st of each year.
  - Verification of a two-step mantoux (TB) testing is required.
  - Verification of MMR vaccination or immunization is required.
- The Waiver of Liability and Health Form is a legal document. The waiver form basically releases the Hospital from liability if a participant is injured in any way. It is a promise not to sue the hospital for any injury and a promise to not allow your health insurer to sue the hospital for payments made on your behalf. Fill out all the forms accurately and honestly.
- Priority for registration will be given to first time participants and applications will be processed on a first come, first served basis.
- **There is a 20 hour maximum job shadowing limit in many of the clinical areas.**

Application Process

Please read the following instructions carefully. If you have any questions, please call Beth Marchant at (937) 499-5015 or Yolanda Munguia at (937) 499-8805 and leave a message with a phone number where you can be reached or e-mail to **jobshadowing@PremierHealth.com**.

1. Determine the facility, career interest you would like to job shadow.
2. Depending on patient/department needs as well as staff availability and the number of requests, we will try to meet your job shadow request. If your request can't be met, you will be contacted and offered an alternative if one is available.
3. Fill out the application form completely. An incomplete application will place your request at the end of the submission list. One application per participant.
4. Fill out the Waiver of Liability and Health Form. You will need to sign and have a parent or guardian sign if you are under the age of 18.
5. Be sure to review the **Premier Health Job Shadow Orientation Brochure** and complete the **Content Review document**.
6. Email the **Application** and **Content Review** documents to **jobshadowing@PremierHealth.com**.
7. You will receive a phone call or e-mail regarding the time and location for your shadow experience.

All paperwork must be completed and turned in no later than the first of the month for job shadow placement for the following month. All applications will be processed on a first come, first served basis. Job Shadow opportunities are limited. You have a better opportunity of receiving your request if it is submitted as far in advance as possible.

JOB SHADOW APPLICATION

Today's Date: ___________________

Name: ____ Age: ________________

Address: ____

City: ________________________________ State: ________________ Zip: _____________

Telephone (with area code): ____

Email address: ____

Name of Parent/Guardian or Emergency Contact: ___________________________________

Emergency Contact Phone Number: ____

High School/College/Other Affiliation ____

Student year: _________________________________

What are you hoping to learn or gain during this job shadow experience? List your objectives.

Please indicate your preference for job shadowing. If your facility choice and date are unavailable, an alternative will be offered. Job shadow availability is filled on a "first come, first served" basis.

Facility Requested:

☐ Atrium Medical Center
☐ Good Samaritan Hospital
☐ Miami Valley Hospital
☐ Other _______________________________________
☐ Miami Valley Hospital South
☐ Premier Health System Support
☐ Upper Valley Medical Center

Career interest you want to shadow:

Clinical
☐ Dietetics/Nutrition
☐ Registered Nursing
☐ Patient Care Technician
☐ Imaging
☐ Respiratory Therapy
☐ Physical or Occupational Therapy
☐ Pharmacy
☐ Physician Assistant
☐ Physician (student must contact and arrange with a physician for shadowing experience prior to completing paperwork) Physician name and facility: ____

Non-Clinical
☐ Hospital administration
☐ Marketing
☐ Plant Operations/Facilities
☐ Human Resources
☐ Information Technology
☐ Environmental Services

Dates Available for Job Shadow:

1. ___________________
2. ___________________
3. ___________________

Hours Requested: _________________

ours requested ____________________

JOB SHADOW WAIVER OF LIABILITY AND HEALTH FORM

PART ONE: WAIVER OF LIABILITY____

For and in consideration of the participation of ________________________(name of participant) in the Premier Health Job Shadow Program, I, for myself, my heirs, executors, administrators, successors and assigns; do hereby release, acquit and forever discharge Premier Health, its agents, employees, and all other persons who might be liable from any and all causes of action, claims and demands of whatsoever nature and kind whether known or unknown arising from my participation in said Program. Further, I, for my heirs, successors, administrators, executors and assigns do hereby covenant not to bring any action against Premier Health, its agents, employees, and all other persons, providing services in the Program and agree to indemnify and hold harmless the same in the event any such action is hereafter brought, or claim is hereafter made.

It is further understood and agreed that I, for my heirs, successors, administrators, and assigns, do hereby agree to indemnify and hold Premier Health, its agents, employees, and all other persons, providing services in the Program with respect to any potential subrogation claims by any and all third party payors with respect to payments made to the Hospital or any other health care or medical providers for health care with respect to any injuries sustained in the course of my participation in the Program.

This release contains the entire agreement between the parties hereto, and the terms of this release are contractual and not a mere recital. I further state that I have carefully read the foregoing release and know the contents hereof, and I sign my name as a free and voluntary act. I, the undersigned student, do hereby acknowledge that I have read and understand the following statements.

I agree to abide by and be bound by the following statements in return for Premier Health allowing me to participate in the Premier Health Job Shadow Program.

1. I will conduct my shadowing activities at Premier Health only under the supervision of a Premier Health employee.
2. I will comply with all Premier Health rules and regulations, Premier Health policies and procedures, Premier Health's Behavior Standards and the Rules of Conduct outlined in this application.
3. I understand that Premier Health retains the right to remove any student at any time.
4. I acknowledge that I am not an employee of Premier Health during the Program.
5. I understand that I am responsible for the cost of any medical care that I receive from Premier Health for any reason.
6. I acknowledge my responsibility and liability regarding the confidential nature of all information that I have access to at Premier Health by virtue of my participation in this Program.
7. I understand that I may not participate in the Job Shadow Program until I have read the Orientation Brochure that includes, but is not limited to, confidentiality, fire safety, infection control, and area specific requirements.

Participation in the Program is prohibited unless this Waiver is signed by the Student (and Parent/Guardian if participant is under the age of 18).

____________________________________	____________________________________
Participant's Signature/Date	Witness
____________________________________	____________________________________
Parent/Guardian Signature/Date (If Participant is under age 18)	Witness

PART TWO: HEALTH REQUIREMENTS

The exam included the tests below. List the DATE and RESULTS of each test.

Annual Influenza Vaccination* Date of Vaccination**: ________________________

Proof of Exemption if Applicable: ______________

*Only required if job shadow experience falls between October 1st and March 31st.
Attach a copy of proof of verification to the Job Shadow Packet.

TB Skin Test

You must complete a two-step Mantoux Testing (tuberculin skin testing) prior to your job shadow experience, please complete step 2 below. **Attach a copy of proof of verification to the Job Shadow Packet.

Step 2:
Two-Step Mantoux Testing (Tuberculin Skin Testing/PPD)(or Chest x-ray if history of +PPD)

Date of Test #1:________________________ Results:_________________

Date of Test #2: ________________________Results:_________________

MMR

Rubella and Rubeola Titer (Documenting Immunity) or Documentation of 2 MMR Vaccines. **Attach a copy of proof of verification to the Job Shadow Packet.

Date of Vaccine#1:________________________

Date of Vaccine #2:________________________

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My signature below confirms that the above information is true, and that to the best of my knowledge I am free of communicable diseases at the time of my observation/job shadow experience at Premier Health. Participation in the Program is prohibited unless this Waiver is signed by the Student (and Parent/Guardian if participant is under the age of 18).

_________________________________ _________________________________
Participant's Signature/Date Witness

_________________________________ _________________________________
Parent/Guardian Signature/Date Witness
(If Participant is under age 18)

PART THREE: ORIENTATION CHECKLIST

Review the information in the Orientation Brochure provided to you. When complete, initial each of the boxes below. Doing so indicates that you read and understood the information presented.

ITEM OF REVIEW:	PARTICIPANT INITIALS:	PARENT/GUARDIAN INITIALS (IF APPLICABLE):
Participant Responsibilities		
Premier Health Mission, Vision, & Values		
Patient Experience		
Cell Phone Usage		
Patient Rights		
Emergency Numbers, Safety Codes, & Your Role		
Infection Control – Hand Washing & Isolation		
Infection Control – Biohazard Waste & Hazardous Spills		
Infection Control – Protection Yourself & Exposure Info		
Confidentiality/HIPAA Info (Information in form attached)		

I agree that I have reviewed the information in the Orientation Brochure as indicated above by my initials. I know that if anything comes up that was not covered within, I can go to my preceptor, the manager of the department I am in, or to a member of the Learning Institute with any questions/concerns.

Participant Signature:_______________________________ **Initials:**_______ **Date:**__________

Parent/Guardian Signature:___________________________ **Initials:**_______ **Date:**__________
(if participant under the age of 18)

STUDENT CONFIDENTIALITY STATEMENT

Security and confidentiality are matters of concern for all persons who have access to Premier Health data and protected health information. Each person accessing Premier Health data and resources holds a position of trust relative to this information and must recognize the responsibilities entrusted in preserving the security and confidentiality of this information. Therefore, all persons who are authorized to access data and resources through all of the Premier Health information systems, access protected health information in any form (electronic, written, verbal), or through personal observation must read and comply with the confidentiality and security policies of Premier Health.

As a condition to receiving access to the information system(s), I agree to comply with the following terms:

_____ I will not access or request data on patients for whom I have no business or job related reason. In addition, I will not access any other confidential information, including financial or protected health information, whether written or electronic.

_____ I understand that the information access through the Premier Health system(s), medical records, or any other method of recording patient information contains sensitive and confidential protected patient health information, business, financial and employee information that should only be disclosed to those authorized to receive it.

_____ I will respect the confidentiality of any protected health information, whether on computer, written, or oral, or reports printed from the Premier Health system(s); and I will handle, store, or dispose of these records in accordance with HIPAA regulations.

_____ I will not intentionally damage, corrupt, or inappropriately delete or destroy any data, protected health information, or computer programs.

_____ I will comply with all policies and procedures and other rules of Premier Health relating to confidentiality of information and login codes to the best of my ability.

_____ I will not serve as an Attorney in Fact or as Power of Attorney of healthcare for a patient and/or client of Premier Health unless the patient and/or client are related to me by blood, marriage, or adoption.

It is the legal, moral, and ethical duty of Premier Health, its employees, students, and those who job shadow to assure a patient's privacy and hold in strictest confidence any and all information concerning the patient and his/her family. No employee shall actively seek to obtain any information regarding patients' illness beyond that which is necessary to carry out assigned tasks.

I understand that my use of the Premier Health computer system(s) will be regularly monitored to ensure compliance with the agreement. I further understand that if I violate any of the above terms, I may be subject to disciplinary action, up to and including termination of contact or any other remedy available to Premier Health.

______________________________	______________________________	__________
Name of Participant (typed or printed)	**Signature of Participant**	**Date**
______________________________	______________________________	__________
Name of Parent/Guardian (if participant is under 18)	**Signature of Parent Guardian**	**Date**

Job Shadow Behaviors and Questions for a Successful Experience:

- This will be an observation experience, no hands-on work is allowed.
- Act like this is a job interview.
- Arrive 10 minutes early.
- Dress appropriately.
- Leave your cell phone at home or in your car.
- Introduce yourself with a smile and a firm handshake.
- Act interested. Be enthusiastic. Ask questions. Be respectful and courteous.
- No gum chewing. Food and water can't be brought to the job shadow.
- If you fall asleep, you will be asked to leave.
- The patient has the right to decline a student's presence during care.
- Thank your professional at the end of the experience.

To get the most from your shadow experience, be prepared to be an active spectator. Take this sheet and a clipboard along with you. When it is appropriate, ask questions and write down the professionals responses. Take time to write down your thoughts and impressions too. This is a worksheet for you and does not need to be turned in.

- What kind of education and skills are needed for this job?
- Do you need a license for this job? If so, what does it take to get a license?
- What is the typical wage for this job?
- How and why did you get started in this job?
- Is this a typical day or is it sometimes different?
- How many hours do you work?
- What do you like the best and least about this job?
- Is continuing education required for this job?
- Does your professional have any advice for you?
- Lastly, a question for you to think about. Do you feel this is the job for you?