CHI Oakes Hospital

Imagine better health.℠

Job Shadowing Program

JOB SHADOWING APPLICATION

Please complete all fields, print, sign, and return to Julie Entzminger, HR Director.

E-mail: julieentzminger@catholichealth.net
Fax: 701-742-3639
Address: 1200 N 7th Street, Oakes, ND 58474

Note: this form is computer-fillable. Incomplete applications will not be considered.

Date: _____

Student Information

Name: _____

Home Address: _____
(street – city – state – zip code)

E-mail Address: _____

Home Phone: _____ Cell Phone: _____

Gender: _____ Date of Birth: _____ Age: _____

High School Information (if applicable)

Name of High School: _____ Grade Level: _____

HS Guidance Counselor: _____

Counselor E-mail address: _____

Counselor phone: _____

College/University Information (if applicable)

Name of College/University: _____ Grade Level: _____

Current/Expected Field of Study: _____

Anticipated Graduation Date: _____

Is this job shadowing learning session required by your college? ☑ Yes ☐ No

Job Shadowing Preferences

- ☐ Laboratory Tech
- ☐ Registered Nurse (general medical, operating room, chemotherapy, or clinic)
- ☐ Licensed Practical Nurse
- ☐ Radiology Tech
- ☐ Physical Therapist
- ☐ Pharmacist
- ☐ Pharmacy Tech
- ☐ Nurse Anesthetist
- ☐ Respiratory Therapist
- ☐ Social Worker
- ☐ Nurse Practitioner
- ☐ Physician Assistant
- ☐ Physician

Dates and Times you are available/not available (i.e. I'm available Mondays and Tuesdays from 8:00 am-2:30 pm, but am not available at all on Wednesdays):

GENERAL PARTICIPANT AGREEMENT

As a participant in the CHI Oakes Hospital Job Shadowing program:

- I will not touch the patients. If I am allowed to observe a patient having a procedure, I understand the director or manager is to obtain the patient's consent first.
- I will not touch medical equipment.
- I understand that I do not have medical record or chart access and will not have computer access.
- I will not assist in feeding but may help deliver food.
- I will not approach providers about personal illness or medications.
- I will dress professionally as outlined in the Dress and Grooming Standards.
- I am subject to CHI Oakes Hospital's drug testing policy. If I object, I will be asked to leave the premises immediately.
- I understand that CHI Oakes Hospital is not held responsible for any accident or injury that may occur on its premises while shadowing.
- I understand that I am to leave all valuables at home.
- I understand that any use of a cellular device is prohibited.
- I will not perform my own personal care in the clinical setting (i.e. applying lip gloss, handling contact lenses, eating or drinking, brushing hair, etc.)
- I understand that I cannot participate in the program on days that I am ill. These include but are not limited to: fever, diarrhea, productive cough, rash, or open wound.
- I understand that I will be required to sign a Student Confidentiality Agreement wherein I agree to keep all patient information confidential. Failure to comply may result in dismissal.
- I understand that CHI Oakes Hospital will have the right to immediately terminate my participation in the program if it is determined at the manager or supervisor's discretion that I am not acting in the best interest of the patient or facility. In addition, the manager or supervisor holds the right to terminate shadowing at any point if deemed necessary.

_____ _____

Signature of Student Date

_____ _____

Signature of Parent/Guardian if Student is a minor Date

OBSERVATION AGREEMENT AND WAIVER

This Observation Agreement and Waiver (hereinafter "Agreement") is between _____, (hereinafter "Student") and **Oakes Community Hospital** (hereinafter "Hospital") in the course of actually performing health care procedures and providing health care services. As a condition of participation, Student and Hospital agree to the following terms and conditions.

The purpose of this Agreement is to set forth the parties' understanding concerning an educational experience that will involve Hospital granting Student access to Hospital's facilities and permission to observe health care personnel performing various clinical and other professional duties. This Agreement does not contemplate the payment of a fee or remuneration by either party to the other, but rather, is intended to jointly benefit both parties by improving educational training and understanding of Student.

1. Student will be allowed to observe patient care only under the supervision of Hospital staff. Student understands that Hospital's patients may refuse to participate in the observation experience.

2. Student agrees to respond promptly to all directions given to Student by medical and nursing staff, including any requests to leave any area, including the procedure room, immediately.

3. Student does not have a medical condition that Student has not disclosed to Hospital employees which may cause injury or illness to Student, to Hospital employees, or to the patients that Student will be observing, Student agrees to inform Hospital employees if Student develops any such condition or disease during the course of Student's participation in the observation program, including, but not limited to: runny nose, fever, rash, etc.

4. If requested by Hospital, prior to participating in an observation experience at Hospital, Student shall provide proof of physical examination, including PPD skin test within thirty (30) days of the start of his or her observation experience at the Hospital, and current immunizations. Immunizations shall include Hepatitis B and/or a signed waiver declining the vaccine, MMR or positives titers and varicella or varicella titer. Proof that Student is in compliance with the above requirements may be submitted to Hospital through a letter from Student.

5. Student agrees to abide by all Hospital policies and procedures at all times while at the Hospital observing procedures or observing the rendering of health care services and undergo any required training regarding universal precautions and infection control; body mechanics; fire/disaster safety; HIPAA and any other training required by Hospital.

6. Student has received copies of relevant Hospital policies and procedures, the *Ethical and Religious Directives,* and the *Ethics @ Work Reference Guide,* and agrees to comply with the terms of these documents.

7. Student agrees to sign a confidentiality agreement and to maintain the confidentiality of any patient information Student has access to or learns while Student is present in the Hospital.

8. Student agrees he or she is not an employee of the Hospital and that he or she will not be entitled to any of the benefits of employment at the Hospital.

9. Hospital and Student will inform each other of any changes in policies or schedules which may affect the Student's observation experience.

10. Student further certifies that he or she is not and at no time has been excluded from participation in any federally funded health care program, including Medicare and Medicaid and further agrees to immediately notify Hospital of any threatened, proposed, or actual exclusion.

11. Student understands that there is a risk of transmission of disease from a patient to Student and that such transmission can occur without any fault or negligence on the part of the Hospital or its employees. Student has health insurance that will provide benefits in the event that Student contracts or develops a medical condition or disease during these observations.

12. Hospital agrees to provide emergency medical care or arrange transportation to receive emergency care if Student becomes ill or suffers an injury requiring emergency care while on Hospital's premises. The cost of medical care will be charged to Student and will be the Student's responsibility, unless such medical treatment is necessitated by the negligence or intentional act of Hospital or its agents or employees, which act or omission occurs within the scope of their agency or employment.

13. Student agrees to indemnify and hold harmless the Hospital and/or any subsidiaries, affiliates, officers, contractors, providers, directors, employees, servants and agents or other third parties designated by these entities or individuals from any liability for any personal injury or potential exposure or property damage which may as a result of Student's presence in the Hospital.

14. If Student is a minor, Student shall have obtained parental/guardian consent required for participation in the observation experience, as well as for any medical examinations, immunizations, and screenings conducted pursuant to this Agreement. Student shall provide copies of such consents to Hospital prior to the beginning of the observation experience.

15. Student understands that failure to comply with the terms and conditions of this Agreement will cause the immediate termination of any right or expectation that Student may have to observe procedures or the rendering of health care services pursuant to this Agreement.

By signing below, the parties acknowledge that they have read this Agreement and Waiver, that they understand its terms, and that they agree to abide by it.

_____ _____

Representative of Hospital Date

_____ _____

Signature of Student Date

_____ _____

Signature of Parent/Guardian if Student is a minor Date

STUDENT CONFIDENTIALITY AGREEMENT

During your observation at Oakes Community Hospital ("Hospital"), you may see clinical, financial, and/or demographic information belonging to our patients. It is the legal responsibility of all Hospital personnel, including medical and nursing students, to protect and preserve confidential patient information in accordance with state and federal law and Hospital policy. As a student engaged in observation at Hospital, you are deemed to be a workforce member under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and as such, you must hold such information in strict confidence. If you are directly observing a specific case, your supervising physician will be responsible for ensuring that the patient has not objected to your observation of their care/treatment.

Confidentiality Agreement

I understand that Hospital has a legal and ethical responsibility to maintain patient privacy, including obligations to protect the confidentiality of patient protected health information ("PHI") and to safeguard the privacy of patient information. I will use and disclose PHI only if such use or disclosure complies with the Hospital policies and procedures, and is required for the performance of my responsibilities as a student in the care and treatment of patients. The use and disclosure of PHI for the purpose of the care and treatment of patients does not include the use or disclosure of PHI for educational endeavors such as writing educational reports for my course of study, or engaging in seminars and presentations in the educational setting.

I will not access or view any PHI other than what is required to perform my responsibilities as a student in the care and treatment of patients. If I have any questions, I will immediately ask my precepting faculty for clarification.

I will not discuss any information pertaining to PHI or Hospital in an area where unauthorized individuals may hear such information (for example, in hallways, on elevators, in the cafeteria, etc.) I understand that it is not acceptable to discuss any PHI in public areas even if specifics such as the patient's name are not used.

I will not make any unauthorized transmissions, copies, disclosures, inquiries, or modifications of PHI. Such unauthorized transmissions include, but are not limited to, removing and/or transferring PHI from Hospital's computer systems to unauthorized locations (for instance, my home or school computer).

Upon termination of my affiliation with Hospital, I will immediately return all property (e.g. keys, documents, ID badges, etc.) to Hospital. I understand that it is my obligation to return all patient PHI to my precepting faculty and Hospital upon completion of my clinical observation at Hospital.

I agree that my obligations under this Agreement regarding PHI will continue after the termination of my affiliation with Hospital.

_____ _____

Student Signature Date

_____

Printed Name

IMMUNIZATION RECORD

Each participant must have up-to-date immunization records for their safety and the safety of our patients. Failure to provide current immunization records or falsified records may result in termination of the application process. Please provide the date of your most recent immunization or submit a copy of your immunization record.

DPT/TDaP (Diptheria, Pertussis, Tetanus) _____

Influenza (Flu Shot – October 1st through April 1st) _____

Hepatitis B _____

Inactivated Poliovirus (Polio Vaccine) _____

MMR (Measles, Mumps, Rubella) _____

Varicella (Chicken Pox) _____

CONSENT FOR EMERGENCY TREATMENT

In the case of an injury while participating in career exploration activities at CHI Oakes Hospital, I give my consent for CHI Oakes Hospital, its physicians, employees and agents to render emergency and other necessary medical treatment. I release CHI Oakes Hospital, its physicians, employees and agents from any costs associated with rendering of treatment to the minor that is necessary in an emergency.

_____ _____

Signature of Student Date

_____ _____

Signature of Parent/Guardian if Student is a minor Date

EMERGENCY CONTACT INFORMATION

Please include the name and contact information of an individual who should be contacted in the event of an emergency.

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email Address: _____