JOB SHADOW OPPORTUNITY REQUEST

Providence Medical Center 1200 Providence Rd Wayne, NE 68787

Last Name:	First Name:	Middle Initial:
Home Address:	License Plate State and Number:	
City, State, Zip:		
Home Phone:	Cell Phone:	
E-mail:	Date of Birth:	
Name of School:	Year in School:	

If you are under 19 please list name and contact information for parent/legal guardian. Parental/Guardian signature will be required on training documentation and they are encouraged to attend training with student.

Name:	
Relationship:	Contact #:

Occupation or department you want to shadow:

Name of person you would like to shadow with, if known:

Briefly describe your reason for wanting to job shadow, including learning and career objectives, number of hours you want to shadow, observational requirements, etc.

What date(s) and time(s) are you available for your job shadow?

Emergency Contact Name (1):	
Relationship:	Phone:
Emergency Contact Name (2):	
Relationship:	Phone:

Do you have any limitations or special needs which need accommodation? Explain:

Have you ever volunteered or been employed by Providence Medical Center? If yes, when?

Have you ever been arrested or convicted of a crime? List dates and charges.

The information provided on this application is true and complete to the best of my knowledge. I have read the self-study orientation.

Date:	Signature:

Providence Medical is an Equal Opportunity Employer and Provider

****Return this form to Human Resources. HR can be reached at 402.375.3800 or hr@providencemedical.com****

JOB SHADOWING AGREEMENT

TERMS OF PROGRAM

In an effort to provide a glimpse or experience as to what interest a career as a health professional may hold for an individual, Providence Medical Center has developed a mentor program in which an interested individual may accompany a staff member of Providence Medical Center on his/her daily routine participating on an observation level only. The individual will not receive compensation or benefit for any time spent at this facility.

Providence Medical Center's primary mission is to provide its patients and our regional community with outpatient, emergency, and inpatient medical services. To accomplish this mission, it may not always be possible to provide appropriate attention by our staff to an interested individual. To this end, the facility, upon the judgment of its designated mentor employee, reserves the right to abruptly end any mentor session when the operation of the facility and service to our patients is in jeopardy of being interrupted in a serious way.

Exposure to patient's blood or body fluids and/or chemicals contained within Providence Medical Center can be potentially dangerous to human life. Any individual involved in the mentor program shall agree that they will never take an active participatory role in the care or treatment of a patient of Providence Medical Center or handle any blood or body fluid from a patient of Providence Medical Center. It may be necessary at times for the hospital staff to ask the individual to wait in a designated area while their mentor is involved in a potentially dangerous task. The mentor will never allow the individual to be exposed to a situation in which he/she may be at risk of contact with a biohazardous substance or infectious agent.

Because of the nature of the business conducted at this facility, the individual involved in the mentor program may be at a considerably higher risk for contracting an infectious disease, despite the best efforts of their mentor. The individual must be aware of these risks and absolve Providence Medical Center from any responsibility, cost or liability associated with any illness or injury acquired while at Providence Medical Center or as a result of their experience at Providence Medical Center.

In the interest of protecting our patients from exposure to an illness from an external source, students should not attend an arranged appointment for educational experience if they are ill. Additionally, we ask that you indicate all vaccinations that you have had. Please check all that apply:

- Tdap (tetanus/diphtheria/pertussis)
- HPV (Human Papilloma Virus) Vaccine
- MCV4 (Meningococcal Conjugate Vaccine)
- Influenza, When? _____
- Pneumococcal Vaccine
- HepB (Hepatitis B Vaccine Series)
- IPV (Inactivated Polio Vaccine)
- MMR (Measles, Mumps, Rubella Vaccine Series)
- Varicella Vaccine Series (Chicken Pox)

Confidentiality is a major concern of patients in a medical facility. Providence Medical Center expects its employees and anyone involved in a mentor program to respect the privacy of its patients. Any information, operation or incident observed or heard while at Providence Medical Center must be kept in strictest confidence. Any breach of confidentiality will result in automatic and immediate expulsion of an individual from the mentor program. If the patient is not willing to allow their care to be a part of the observation process, the student will be asked to remain in a designated area until retrieved by their mentor.

An individual in the mentor program is expected to exhibit a professional attitude and behavior while on the premises of Providence Medical Center. They must obey the rules and regulations of this institution and any instructions given to them by their mentor. Providence Medical Center requires and provides training at no cost to the individual to ensure awareness of expectations while participating in the educational opportunity.

An individual involved in the mentor program can also expect a willing and patient attitude to be exhibited by their mentor. The mentor should demonstrate a desire to convey the aspects of their profession to the student in a helpful and cheerful manner. The individual may request another mentor be assigned to them if these attributes are not demonstrated.

Providence Medical Center will not discriminate against any individual interested in the mentor program because of race, religion, color, gender, sexual orientation, gender identity, national or ethnic origin, disability, or marital status.

Providence Medical Center will not be responsible for any costs incurred by the individual involved in the mentor program as a result of their participation.

Students must dress in a professional manner during their observational experience at Providence Medical Center. If the student arrives at the hospital and is not dressed appropriately, they will not be allowed to proceed with their observational experience on that day or until they can return in appropriate attire. Students must also turn off their cell phones during their observational experience. Examples of *prohibited apparel*:

- T-shirts with slogans or sayings.
- Spaghetti strap top, halter, tank or tube tops.
- Beach wear.
- Shorts or cut offs (including Bermuda shorts the length less than 2" above the knee – unless part of department uniform.)
- Dirty, ripped, wrinkled or stained clothing.
- Transparent or tight garments.
- Footwear must be clean, safe and appropriate for the work area. No beach type flip-flops, or other inappropriate footwear. Open toed shoes are prohibited in patient care areas. If unsure of proper footwear for your area check with your supervisor.
- Sleeveless tops.
- Sweatpants or boxer shorts.
- Any shirt with mid-drift exposure or off the shoulder tops.
- Women's skirts must be longer than two inches above the knee.
- Piercing of facial parts such as the nose, eyebrows, tongue and lips are prohibited.
- The student will be required to cover a tattoo when on duty or representing Providence Medical Center.
- Providence Medical Center prohibits artificial nails in all patient care areas and lab.

AGREEMENT AND WAIVER

I agree to the terms presented in this document for involvement in the mentor program. In addition to the terms presented in this document, I have received training from Providence Medical Center outlining the terms in greater detail. I waive all rights to benefits and compensation for participation in the program. To the extent provided by law, I agree to indemnify and hold harmless Providence Medical Center from any and all costs, expenses, claims, demands, causes of action, liabilities and responsibilities arising out of any act or omission on my part. I will be involved in the mentor program at Providence Medical Center, 1200 Providence Road, Wayne, Nebraska from _____ to _____(training provided by Providence Medical Center can be accepted for program for one year prior to clinical experience/job shadowing opportunity). Terms of this agreement are in force for the duration of this time.

_____ _____
Individual involved in Mentor program Date

_____ _____
Parent of Student if under 19 years of age Date

_____ _____
Departmental Supervisor Date

_____ _____
Designated Mentor Date

_____ _____
Hospital CEO Date

Confidentiality Agreement for Student Experience

Confidentiality is a major concern of patients in a medical facility. Providence Medical Center expects its employees, volunteers, contracted employees and anyone involved in any kind of educational experience to respect the privacy of its patients. Any information, operation or incident observed or heard while at Providence Medical Center must be kept in strictest confidence. Any breach of confidentiality will result in automatic and immediate expulsion of an individual from the educational experience.

An individual involved in an educational experience at PMC is expected to exhibit a professional attitude and behavior while on the premises. They must obey the rules and regulations of this institution and any instructions given to them by their mentor. Providence Medical Center reserves the right to require safety in-service at no cost to the individual if it is deemed necessary.

The Federal Health Insurance Portability Accountability Act (HIPAA) Privacy Law governs the release of patient identifiable information by hospitals and other health care providers. This law establishes protections to preserve the confidentiality of various medical and personal information and specify that such information may not be disclosed except as authorized by law or the patient or individual.

Confidential Patient Care Information includes: Any individually identifiable information in possession or derived from a provider of health care regarding a patient's medical history, mental, or physical condition or treatment, as well as the patients and/or their family members records, test results, conversations, research records and financial information. Examples include, but are not limited to:

• Physical medical and psychiatric records including paper, photo, video, diagnostic and therapeutic reports, laboratory and pathology samples;

• Patient insurance and billing records;

• Mainframe and department based computerized patient data and alphanumeric radio pager messages;

• Visual observation of patients receiving medical care or accessing services; and

• Verbal information provided by or about a patient.

Confidential Employee and Business Information include, but are not limited to, the following:

• Employee home telephone number and address;

• Spouse or other relative names;

• Social Security number or income tax withholding records;

• Information related to evaluation of performance;

• Other such information obtained from PMC's records which if disclosed, would constitute an unwarranted invasion of privacy; or

• Disclosure of Confidential business information that would cause harm to Providence Medical Center.

CONFIDENTIALITY STATEMENT

I understand and acknowledge that:

1. I shall respect and maintain the confidentiality of all discussions, deliberations, patient care records and any other information generated in connection with individual patient care, risk management and/or peer review activities.

2. It is my legal and ethical responsibility to protect the privacy, confidentiality and security of all medical records, proprietary information and other confidential information relating to Providence Medical Center, including business, employment and medical information relating to our patients, members, employees and health care providers.

3. I shall only access or disseminate patient care information in the performance of my assigned duties and where required by or permitted by law, and in a manner which is consistent with officially adopted policies of Providence Medical Center, or where no officially adopted policy exists, only with the express approval of my supervisor or designee. I shall make no voluntary disclosure of any discussion, deliberations, patient care records or any other patient care, peer review or risk management information, except to persons authorized to receive it in the conduct of Providence Medical Center affairs.

4. Providence Medical Center performs audits and reviews patient records in order to identify inappropriate access.

5. If provided to me, my user ID is recorded when I access electronic records and that I am the only one authorized to use my user ID. Use of my user ID is my responsibility whether by me or anyone else. I will only access the minimum necessary information to satisfy my job role or the need of the request.

6. I agree to discuss confidential information only in the work place and only for job related purposes and to not discuss such information outside of the work place or within hearing of other people who do not have a need to know about the information.

7. I understand that any and all references to HIV testing, such as any clinical test or laboratory test used to identify HIV, a component of HIV, or antibodies or antigens to HIV, are specifically protected under law and unauthorized release of confidential information may make me subject to legal and/or disciplinary action.

8. I understand that the law specially protects psychiatric and drug abuse records, and that unauthorized release of such information may make me subject to legal and/or disciplinary action.

9. My obligation to safeguard patient confidentiality continues after my termination of my educational experience at Providence Medical Center.

I hereby acknowledge that I have read and understand the foregoing information and that my signature below signifies my agreement to comply with the above terms. In the event of a breach or threatened breach of the Confidentiality Agreement, I acknowledge that Providence Medical Center may, as applicable and as it deems appropriate, terminate my educational experience at Providence Medical Center.

Print Name:_____

Signature:_____

Department: _____

Dated:_____