JOB SHADOWING EXPERIENCE APPLICATION FORM

Today's Date: ___________________________

Individual's Name: ____ Phone: ________________

Email:
____

If under 18 years of age: Age:_______________________ DOB:___________________________

Dates requested for shadowing: ____

Have you contacted an employee/physician and/or department in our facility about job shadowing? Yes_____ No_____

If yes, who? ________________________________ Department________________________________

School Name (if applicable):_________________________________ Phone:
____

*Contact Person Name: (if applicable): ____________________ Phone: ______________________

Individual's Signature: ______________________________________Date: ______________________

Please be sure all of the following forms are attached to this sheet:

- ❑ Adult Release of Liability
- ❑ Parental Permission and Release of Liability (if applicable)
- ❑ HIPAA Summary/Confidentiality Agreement
- ❑ Influenza Vaccination Consent/Declination Form with proof of vaccine
- ❑ Proof of Negative TB Test/Chest X-ray in past year
- ❑ Proof of Identity
- ❑ Hand Hygiene Education Attestation

Please deliver or fax (386-943-3657) completed forms to the Education Department at least 2 weeks in advance of requested job-shadowing experience date.

ADULT RELEASE OF LIABILITY

Name:______________________________ Date of Birth:__________________________

Address:____

City:______________________________ State:____ Zip:___________________________

Home Phone:_______________________ Work Phone:__________________________

Release of Liability

I, ____________________________ shall indemnify and hold harmless, AdventHealth DeLand, its agents, servants, employees, officers, and directors from any and all liability for accidents, personal injury, or illness, arising or alleged to have risen out of my participation in any/all activities during the shadowing experience. If I am involved in an accident requiring treatment, AdventHealth DeLand is authorized to treat me in the Emergency Department. I will be responsible for all expenses incurred for such treatment.

______________________________________ ___________________________
Signature Date

______________________________________ ___________________________
Witness Date

PARENTAL PERMISSION AND RELEASE OF LIABILITY

(To be completed only if individual is under the age of 18)

Child's Name:________________________________Date of Birth:_________________________________

SS#:____________________________________ Grade:____

Address:____

____

City:_______________________________________State:______________________Zip:______________

Home Phone:________________________________Work Phone:__________________________________

Parental Consent:

(I) (We), the undersigned parent(s) of ____, a minor, do hereby consent to said minor participating in the job shadowing program conducted by AdventHealth DeLand. This authorization shall be effective on the day of___________, 20____.

Release of Liability:

____ (Parent(s) name), shall indemnify and hold harmless, AdventHealth DeLand, its agents, servants, employees, officers, and directors from any and all liability for accidents, personal injury, or illness, arising or alleged to have risen out of ____ (minor's name) participation in job shadowing program conducted by AdventHealth DeLand.

____ ____________________________

Parent Signature Date

____ ____________________________

Parent Signature Date

____ ____________________________

Witness Date

HIPAA SUMMARY & CONFIDENTIALITY AGREEMENT

HIPAA - Health Insurance Portability and Accountability Act is based on federal regulations that protect patient information.

PHI - Patient Health Information.

1. DO NOT DISCUSS PATIENT INFORMATION with anyone without the "need to know". That is, no one outside of those who are caring directly for the patient.

2. What information you read, see, or hear regarding a patient and their treatment is to be kept confidential. DO NOT share information with family or friends.

3. BEFORE looking at information ask, "Do I need to know this to do my job?" If the answer is NO…then STOP!!!

4. DO NOT share passwords for computer systems. There are monitoring programs which are run for security reasons to see who has accessed, and who has the right to access the patient's information.

5. Be VERY careful who is around (and where you are) when discussing any patient information between those who are caring for the patient. Remember, there are family members and other persons present in hallways, elevators, and the cafeteria who have no right to the information.

6. Information regarding a patient may only be released by patient / guardian authorization for information NOT PROTECTED under the Federal regulations.

CONFIDENTIALTY- I, ____________________wish to participate in the job shadowing program that will provide me with the opportunity to follow AdventHealth DeLand personnel as they perform some of their daily activities. I understand that I will have access to information about patients that is highly confidential and personal, and I also understand that the confidentiality of that information is protected by state and federal law. I agree not to disclose to any person the identity of any patient I may see in the hospital and not to otherwise discuss or disclose any information I may receive, directly or indirectly, regarding the reason for any patient's admission to the Hospital or any treatment they may receive.

______________________________ ______________________________
Printed Name Signature

____
Date