JOB SHADOWING EXPERIENCE CONTACT FORM

Individual's Name: _____ Phone: _____

Email: _____

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: _____

*School Contact Person Name: (if applicable): _____ Phone: _____

Individual's Signature: _____Date: _____

*Contact Person Signature: _____Date: _____

(*school instructor/counselor/AdventHealth Director if applicable)

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

- ❑ Adult Release of Liability **or** Parental Permission and Release of Liability
- ❑ HIPAA Summary/Confidentiality Agreement
- ❑ Photography/Video Agreement and Release
- ❑ Proof of Influenza Vaccination
  or ❑ Influenza Declination Statement signed and provided: _____
- ❑ Proof of Covid Vaccination
  or ❑ Covid Vaccination Declination Statement signed and provided: _____
- ❑ Proof of negative TB test or chest x-ray (within last 12 months)
- ❑ Adults 18 and over: copy of current, valid state/government-issued ID

Please deliver completed forms to the Education Department at least 1 week 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, 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 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:_____

Address:_____

_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell 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. This authorization shall be effective on the _____day of_____, 20___.
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Release of Liability:
_____ (Parent(s) name), shall indemnify and hold harmless, AdventHealth, 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.

_____ _____
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 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

PHOTOGRAPHY/VIDEO AGREEMENT & RELEASE
(NON-PATIENT ADULTS & MINORS)

I, on behalf of myself, or if the subject is a minor, on behalf of my minor child, grant to AdventHealth on a perpetual, irrevocable and unrestricted basis the right to use, reuse, publish and re-publish photographic portraits or pictures and/or video tape footage of the Subject (the "Subject's Likeness"), in which the Subject's Likeness may be included as a composite or distorted in character or form, and whether in conjunction with the Subject's own name or a fictitious name. The right granted herein to use the Subject's Likeness shall extend to any reproductions in color or otherwise, made through any medium and in any and all media now or hereafter known whether employed singularly or in conjunction with printed and/or other accompanying material and whether employed for any purpose whatsoever, and regardless of the manner in which said use is transmitted.

The Subject waives any right to inspect or approve the finished product or products and/or the advertising copy or other matter containing the Subject's Likeness. The Subject further waives any right to compensation received by AdventHealth in association with the commercialization of the Subject's Likeness.

THE SUBJECT RELEASES AND AGREES TO HOLD HARMLESS ADVENTHEALTHM, ITS EMPLOYEES, OFFICERS AND AGENTS, FROM ANY LIABILITY ASSOCIATED WITH THIS GRANT, INCLUDING WITHOUT LIMITATION ANY CLAIMS FOR LIBEL OR INVASION OF PRIVACY.

For purposes of this grant, the term "AdventHealth" shall include all business entities, which are now or in the future owned or controlled or managed by AdventHealth.

I warrant that I am over the age of 18 and have the right to contract in my name, or on behalf of the Subject, if the Subject is a minor child. I have read and understand the content of this document prior to signing it. This release shall be binding upon the Subject, his heirs, legal representatives and assigns, and the individual (including the individual's heirs, legal representatives and assigns) executing this document in those circumstances where the Subject is a minor child.

Subject Name _____ Signature _____

Subject Minor's Name _____ Authorized Signature_____

Address _____

Phone Number _____ Date _____

Declination of Influenza Vaccination

AdventHealth per guidelines from CDC and CMS has recommended that I receive the flu vaccine to protect the community I serve.

I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease that kills thousands of people annually
- Influenza vaccination is recommended for me and all other healthcare workers
- If I contract influenza, I can shed the virus for 48 hours prior to when flu symptoms appear
- If I become infected with influenza, I can spread flu to others even when my symptoms are mild or non-existent including to patients in this facility and my own family members
- I understand that the strains of virus that cause influenza infection change almost every year and, even if they don't change, my immunity declines over time. This is why vaccination against influenza is recommended each year
- I understand that I cannot get influenza from the influenza vaccine
- The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact from influenza including
    - all patients in this healthcare facility
    - my coworkers
    - my family
    - my community

Despite these facts, I am choosing to decline influenza vaccination for the following reasons:

- ☐ Medical Reason
- ☐ Religious Reason

I am aware that I can change my mind at any time and accept influenza vaccination, if vaccine is still available. I also understand that I must wear a surgical mask if I am in an area where I may come in contact with a patient if I remain unvaccinated during Influenza Season from October through April (these dates are subject to change due to local Flu activity).

I have read and fully understand the information on this declination form.

Signature: _____ Date: _____

Name (print): _____ Department:_____

Declination of Covid Vaccination

AdventHealth per guidelines from CDC and CMS has recommended that I receive the covid vaccine to protect the community I serve.

I acknowledge that I am aware of the following facts:

- Influenza vaccination is recommended for me and all other healthcare workers
- If I contract covid, I can shed the virus prior to when covid symptoms appear
- If I become infected with covid, I can spread flu to others even when my symptoms are mild or non-existent including to patients in this facility and my own family members
- I understand that I cannot get covid from the covid vaccine
- The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact from covid including
    - all patients in this healthcare facility
    - my coworkers
    - my family
    - my community

Despite these facts, I am choosing to decline covid vaccination for the following reasons:

- ☐ Medical Reason
- ☐ Religious Reason

I am aware that I can change my mind at any time and accept covid vaccination, if vaccine is still available. I also understand that I must wear a surgical mask at all times within an AdventHealth facility.

I have read and fully understand the information on this declination form.

Signature: _____ Date: _____

Name (print): _____ Department:_____