Job Shadow Application

Thank you for your interest in the Regional West Shadow Experience Program. We are excited that you are interested in a possible career in the medical field. If you are 16 years of age or younger, please complete this form with a parent's signature. You may deliver the application to Regional West by dropping it off at the Birth and Infant Care Center entrance at door 6, or fax it to 308-630-1792.

Name: _____ Date of Birth: _____

Age: _____

High School Graduation Year: _____

School or College: _____

Home Address: _____ City, State, Zip:_____

Phone Number: _____ Email Address: _____

What jobs or departments are you in interested in shadowing?
1st Choice: _____
2nd Choice: _____
3rd Choice: _____

Why do you wish to shadow in these areas?

_____

_____

Do you have a health care professional in mind with whom you like to shadow?

_____

What do you hope to learn from the experience?

_____

Please list three dates at least two weeks from now (in order of preference) that you wish to shadow. If only specific hours work on these days, please note that as well. If unsure of possible shadowing dates, leave blank and contact us later with definite dates.

1._____ 2. _____ 3. _____

Number of shadowing hours desired: _____
(If you need hours tracked, please provide the necessary form.)

Signature: _____

Job Shadow Agreement and Authorization to Participate

1. **Waiver of Liability.** In consideration that I am being permitted to participate in Regional West Health Services' workforce development program (e.g., job shadowing, observations, activities, etc.), I, undersign, in full recognition and appreciation of the dangers and hazards inherent in this activity, agree to assume all risks and responsibilities surrounding my participation in this activity. Further, I do for myself, my child/children, my heir and personal representative(s) agree to defend, hold harmless, indemnify, release, and forever discharge Regional West Health Services, and its officers, agents, and employees from and against any and all future claims, demands, or causes of action, on account of damage to personal property, personal injury or death which may result from my participation in any Regional West Health Service career–related program.
2. **No Cell Phones.** I understand while job shadowing at Regional West Health Services, any usage of cellular devices are prohibited. All patient information and results must be kept confidential and may be report only to those professionals directly involved with the patient's treatment and care. Failure to comply may result in dismissal from the site.
3. **Confidentiality.** I agree that I shall not**,** at any time during the job shadow or after it has concluded, divulge or convey any confidential information, trade secrets, business plans, proprietary information, knowledge, data or property related to Regional West Health Services or any of its affiliates or patients other than that which is in the public domain, unless authorized by Regional West Health Services in writing. This specifically means that I may not share details about the program or any patients (or their families) that I may come into contact with in any social media form, such as Facebook, Instagram, SnapChat, etc. In the event of any violation or threatened violation of this section, Regional West Health Services shall be entitle to immediate injunctive or other equitable relief in addition to any other remedies to which Regional West Health Services may be entitled to under law.
4. **HIPAA.** The Health Insurance Portability and Accountability Act (HIPAA) was enacted by Congress in 1996. HIPAA specifically protects the confidentiality of each individual's health information, and provides criminal penalties and fines for persons that breach that confidentiality. The job shadow program will place you in a medical environment and you will be personally responsible for complying with HIPAA; failure to do so may/will result in criminal prosecution. You understand you are required to receive necessary HIPPA training as directed by Regional West Health Services and you are responsible for following all policies and expectations of any employee. You may find more information about HIPAA and your responsibilities at www.hhs.gov/hipaa/.
5. **No Entitlements to Benefits or Wages.** I understand that I am not an employee of Regional West Health Services or any of its subsidiaries or affiliates, and am not entitled to any wages or benefits, including, but not limited to: social security benefits, workers' compensation benefits, and retirement benefits.
6. **Responsibility to Cover Costs.** I understand and agree that I am solely responsible for any costs that I may incur by participating in the job shadowing program. These costs may include, but are not limited to: health screening, transportation, meals, and parking.
7. **Compliance with Law / Policies.** I understand and agree to abide by any and all applicable laws, regulations, and policies adopted by Regional West Health Services, including the Code of Ethics.
8. **Deadlines.** I understand the submission of the job shadow application must be minimum of **14 days PRIOR** to the desired start date of the experience. I also understand it may take two to three weeks to arrange a schedule to shadow.
9. **Dates**. The expected start date of shadowing is _____.
10. **Health Insurance / Exposure to Infectious Agents.** I understand that the job shadow program will take place in a medical facility and that I may be exposed to infectious agents including blood borne pathogens. I hereby represent and warrant that I have health insurance and agree to be liable for any charges for services I may receive related to emergency care and/or testing to determine exposure to infectious agents. I understand that Regional West Health Services will/may require certain immunizations prior to my experience and I will provide proof of such vaccinations, including the influenza vaccination.
11. **Indemnification.** I agree to indemnify and hold harmless Regional West Health Services, its subsidiaries, affiliates, officers, directors, agents, employees, and representatives ("Indemnified Parties" jointly and severally) from and against any and all liabilities or related, arising out of or in connection with the job shadow program, incurred by my wrongful acts, omissions, or misconduct. This shall be specifically construed to include, but not be limited to, any violation of the Health Insurance and Portability Act (HIPAA).
12. **Acknowledgement.** I have read the job shadow/observation request form for Regional West Health Services and hereby certify that all information provided in this request is accurate, and that submission of this request does not guarantee placement into an experience. I further understand that approval and placement of an experience is at the discretion of Regional West Health Services, and may require additional health screening. Regional West Health Services may terminate a job shadow at any time and for any reason.

Job Shadow Agreement and Authorization to Participate

HAVING READ AND UNDERSTOOD THIS AGREEMENT, I VOLUNTARILY AND KNOWINGLY SIGN BELOW

_____	_____	_____
Applicant Name	**Applicant Signature**	**Date**

Permission of Parent (required of any student under the age of 19)

I grant my child, _____, who is 16 years of age or older, permission to participate in the approved Regional West Health Services Shadow Experience. I understand that he/she may be exposed to patient information and that he/she is responsible for keeping it confidential. I also recognize that he/she may be exposed to potential risks as a result of this experience and agree to not hold Regional West Health Services liable for any harm or injury as a result of this experience.

Parent/Guardian's Signature: _____

Date: _____

Job Shadow Confidentiality Statement

Regional West Health Services has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their health and financial information. Protected health information may include but is not limited to: names, dates of birth, diagnoses, pictures, and financial information. Remember, the mere fact that someone is in the facility is confidential! Just don't talk about it!

As a Shadow Candidate or Business Associate, I have received training, and understand and agree that I must hold all patient information in confidence. This includes the names of person(s) I may encounter while in the facility, and/or any information relating to that person(s). I am not to disclose **any** Protected Health Information (PHI) to any unauthorized source or person(s). This includes my family, spouse, children, and parents.

I understand that any breach of confidentiality is a violation of this agreement and that breach will result in me being barred from the facility as a Job Shadow Candidate in the future. Furthermore, I understand a violation may affect the Job Shadow Program and/or affiliation agreement for other students. I understand this document must be signed annually to ensure understanding and compliance.

In the event that a breach of confidence occurs by a Job Shadow Candidate, depending on the harm caused, the candidate and/or their parents (when applicable), may face legal charges. If you become aware of a breach of **any** Protected Health Information, please contact the Privacy Officer at 308.635.3711.

Signature: _____ Date: _____
Job Shadow Candidate

Expires: _____

Signature: _____ Date: _____
Regional West Health Services Representative

Regional West

SHADOW IMMUNIZATION REQUIREMENTS
(COPIES OF DOCUMENTS MUST BE ATTACHED TO QUALIFY)

Name: _____Date Of Birth: _____
Start Date: _____End Date: _____Phone Number: _____

Record of Varicella Vaccines x2
#1date: _____
#2date: _____
OR Varicella lab IgG positive/immune date: _____

Record of Hepatitis B Vaccines x3
#1date: _____
#2date: _____
#3date: _____
OR Hepatitis B antibody lab positive/immune date: _____

Record of Measles, Mumps, Rubella (MMR) Vaccines x2
#1date: _____
#2date: _____
OR Measles lab IgG positive/immune date: _____
Mumps lab IgG positive/immune date: _____
Rubella lab IgG positive/immune date: _____

Record of influenza vaccination during flu season (October 1 through May 31)
Date: _____

Record of tetanus, diphtheria, and pertussis (Tdap) vaccination date: _____

TUBERCULOSIS (TB) SCREENING

YES	NO	NA	
			Have you ever had a **positive** TB skin test or positive Quantiferon Gold TB lab test?
			Have you ever been told not to have a TB skin test because you are allergic to the products it is made of?
			Have you ever received the Bacillus Calmette-Guerin (BCG) vaccine (This vaccine is only given outside of the United States)?
			Have you ever been exposed to TB (for example, family member, friends, or occupation)?
			Have you ever traveled outside of the United States?

			Have you had any symptoms such as a productive cough (over three weeks duration), fever, chills, night sweats, easy fatigability, loss of appetite, weight loss, or hemoptysis (coughing up blood or blood in your sputum)?

_____ _____

Signature/Print Name Date

If needed Tuberculosis (TB) testing

Negative TB skin test within last 12 weeks date _____**and** Negative within last 12 months date_____

OR Negative Quantiferon Gold TB lab test within last 12 weeks date_____.

Submit Form