Premier Health

Job Shadow Application

Premier Health Employee Job Shadowing Program

Thank you for choosing to participate in our Premier Health Employee job shadowing program. Our employee job shadowing program is an observation only experience for any employee seeking career development opportunities or any employee interested in learning more about daily duties of their colleagues. We offer both clinical and non-clinical job shadowing experiences. Participants may schedule **one 2 to 8 hour** job shadow session per calendar year. These observation hours are separate from clinical hours needed for an education program. Any questions about the program can be sent to jobshadowing@premierhealth.com

Peer Job Shadow Requirements:

- ☐ Participant must submit a completed Employee Job Shadowing Application
- ☐ Participants must certify that all required immunizations and tests are up-to-date and maintained by Employee Health. Required immunizations and tests include the following:
  - ☐ MMR
  - ☐ Varicella
  - ☐ Rubella and Rubeola Titer
  - ☐ Hepatitis B
  - ☐ Tetanus, Diphtheria, Pertussis (TDAP)
  - ☐ COVID-19
  - ☐ Influenza
  - ☐ TB (Negative skin or blood test from anytime in the past and negative annual screening)

Submitting Application:

- ☐ Participants without a pre-arranged job shadow colleague must submit a completed application at least **4 weeks** prior to the job shadow request date
- ☐ Participants that have arranged a job shadow experience with a colleague, must submit a completed application at least **1 week** prior to job shadow experience
- ☐ All applications can be submitted to jobshadowing@premierhealth.com

Participating Facilities:

- Atrium Medical Center
- Premier Health System Support
- Upper Valley Medical Center
- Miami Valley Hospital North
- Miami Valley Hospital
- Miami Valley Hospital South

Clinical Career Interest Include:

- Dietetics/Nutrition
- Respiratory Therapy
- Registered Nurse
- Physical or Occupational Therapy
- Patient Care Technician
- Laboratory
- Medical Imaging
- Surgical Tech
- Physician's Assistant
- Physician

Non- Clinical Career Interest Include:

- Hospital Administration
- Human Resources
- Plant Operations/Facilities Mgt.
- Marketing/Communication
- Environmental Services
- Information Technology

Employee Job Shadow Application

Participant Information:

Date: _____ **Name**: _____

Department: _____ **Premier Facility**: _____

Phone Number: _____ **Email:** _____

Emergency Contact: _____ **Emergency Contact Number:** _____

Area of Interest:

If you do not have a contact for the department that you want to shadow, please complete the below and leave the employee contact information sections blank

Job Shadow Request Date(s): _____

Department: _____ **Premier Facility**: _____

Name of Employee you will be shadowing with: _____

Employee's Email Address: _____

JOB SHADOW WAIVER OF LIABILITY AND HEALTH FORM

For and in consideration of the participation of _____ (name of participant) in the Premier Health Job Shadow Program, I, for myself, my heirs, executors, administrators, successors and assigns; do hereby release, acquit and forever discharge Premier Health, its agents, employees, and all other persons who might be liable from any and all causes of action, claims and demands of whatsoever nature and kind whether known or unknown arising from my participation in said Program. Further, I, for my heirs, successors, administrators, executors, and assigns do hereby covenant not to bring any action against Premier Health, its agents, employees, and all other persons, providing services in the Program and agree to indemnify and hold harmless the same in the event any such action is hereafter brought, or claim is hereafter made.

It is further understood and agreed that I, for my heirs, successors, administrators, and assigns, do hereby agree to indemnify and hold Premier Health, its agents, employees, and all other persons, providing services in the Program with respect to any potential subrogation claims by any and all third party payors with respect to payments made to the Hospital or any other health care or medical providers for health care with respect to any injuries sustained in the course of my participation in the Program.

This release contains the entire agreement between the parties hereto, and the terms of this release are contractual and not a mere recital. I further state that I have carefully read the foregoing release and know the contents hereof, and I sign my name as a free and voluntary act. I, the undersigned student, do hereby acknowledge that I have read and understand the following statements.

I agree to abide by and be bound by the following statements in return for Premier Health allowing me to participate in the Premier Health Job Shadow Program.

1. I will conduct my shadowing activities at Premier Health only under the supervision of a Premier Health employee.
2. I will comply with all Premier Health rules and regulations, Premier Health policies and procedures, Premier Health's Behavior Standards and the Rules of Conduct outlined in this application.
3. I understand that Premier Health retains the right to remove any student at any time.
4. I acknowledge that I am not an employee of Premier Health during the Program and will not receive any monetary compensation or benefits for participating in the Program.
5. I understand that I am responsible for the cost of any medical care that I receive from Premier Health for any reason.
6. I acknowledge my responsibility and liability regarding the confidential nature of all information that I have access to at Premier Health by virtue of my participation in this Program.
7. I understand that I may not participate in the Job Shadow Program until I have read the Orientation Brochure that includes, but is not limited to, confidentiality, fire safety, infection control, and area specific requirements.
8. I certify that all of my required immunization and testing information is up-to-date and maintained by Premier Employee Health.

Participation in the Program is prohibited unless this Waiver is signed by the participant (and Parent/Guardian if participant is under the age of 18).

_____ _____

Participant's signature / Date | Witness

_____ _____

Parent / Guardian Signature / Date (If Participant is under age 18) | Witness

Tuberculosis (TB) Screening Health Questionnaire/ Risk Assessment

Name: _____ ID/Badge #: _____

Hospital facility (or offsite location) where you work: _____ Dept: _____

Please answer each question.

Do you have any of the following? (CHECK YES OR NO)

	YES	NO
1. Coughing up blood	☐	☐
2. A productive cough lasting 3 or more weeks	☐	☐
3. Persistent weight loss without dieting	☐	☐
4. Persistent low-grade fever	☐	☐
5. Recurrent night sweats	☐	☐
6. Prolonged loss of appetite	☐	☐
7. Swollen glands	☐	☐
8. Shortness of breath	☐	☐
9. Have you had INH therapy (6-9 months on medication after testing positive to TB)	☐	☐
	YES	NO
10. Have you had temporary or permanent residence of ≥ 1 month in a country with a high rate of TB?	☐	☐
11. Are you on current or planned immunosuppression? (chronic steroid use or other immunosuppressants)?	☐	☐
12. Have you had close contact with someone who has had infectious TB since your last TB screening?	☐	☐

Please explain any YES answers:

_____

_____

_____

_____

_____

_____ _____

Participant's Signature / Date

Parent/Guardian Signature / Date
(If Participant is under age 18)

CONFIDENTIALITY STATEMENT

Security and confidentiality are matters of concern for all persons who have access to Premier Health data and protected health information. Each person accessing Premier Health data and resources holds a position of trust relative to this information and must recognize the responsibilities entrusted in preserving the security and confidentiality of this information. Therefore, all persons who are authorized to access data and resources through all of the Premier Health information systems, access protected health information in any form (electronic, written, verbal), or through personal observation must read and comply with the confidentiality and security policies of Premier Health.

As a condition to receiving access to the information system(s), I agree to comply with the following terms:

_____ I will not access or request data on patients for whom I have no business or job related reason. In addition, I will not access any other confidential information, including financial or protected health information, whether written or electronic.

_____ I understand that the information access through the Premier Health system(s), medical records, or any other method of recording patient information contains sensitive and confidential protected patient health information, business, financial and employee information that should only be disclosed to those authorized to receive it.

_____ I will respect the confidentiality of any protected health information, whether on computer, written, or oral, or reports printed from the Premier Health system(s); and I will handle, store, or dispose of these records in accordance with HIPAA regulations.

_____ I will not intentionally damage, corrupt, or inappropriately delete or destroy any data, protected health information, or computer programs.

_____ I will comply with all policies and procedures and other rules of Premier Health relating to confidentiality of information and login codes to the best of my ability.

_____ I will not serve as an Attorney in Fact or as Power of Attorney of healthcare for a patient and/or client of Premier Health unless the patient and/or client are related to me by blood, marriage, or adoption.

It is the legal, moral, and ethical duty of Premier Health, its employees, students, and those who job shadow to assure a patient's privacy and hold in strictest confidence any and all information concerning the patient and his/her family. No employee shall actively seek to obtain any information regarding patients' illness beyond that which is necessary to carry out assigned tasks.

I understand that my use of the Premier Health computer system(s) will be regularly monitored to ensure compliance with the agreement. I further understand that if I violate any of the above terms, I may be subject to disciplinary action, up to and including termination of contact or any other remedy available to Premier Health.

Name of Participant (typed or printed)	**Signature of Participant**	**Date**
Name of Parent/Guardian (if participant is under 18)	**Signature of Parent Guardian**	**Date**