Premier Health

Job Shadow Application

Premier Health Job Shadowing Program

Thank you for choosing Premier Health for your Healthcare job shadowing experience. Our job shadowing program is an **observation** only experience in a select clinical or non-clinical department based on availability. Participants will be allowed to schedule **one 2 - 8 hour** job shadow per calendar year. Exceptions are made for participants needing extended job shadowing for entry into a career or college program, or to meet requirements for a program of study Please send all questions and completed forms to jobshadowing@premierhealth.com.

Job Shadow Requirements:

- ☐ Participants must complete a job shadowing application
- ☐ Participants must be at least 14 years old; 16 years old to shadow in the Operating Room or Emergency Department
- ☐ Participants must complete the Health and Liability form attached hereto and certify that they have completed the following immunizations or provide proof of exemptions:
    - ☐ MMR, Hepatitis B, Varicella, Tdap and COVID-19 immunizations
    - ☐ Annual Influenza (October -March)
    - ☐ TB (Negative skin or blood test from anytime in the past and negative annual screening)

Application Process:

- ☐ Review the Premier Health Job Shadowing Orientation Brochure available at the below link:
    - p-w-com83710-job-shadowing-booklet.pdf (premierhealth.com)
- ☐ Participants shadowing a Physician must have approval from physician prior to applying to job shadow
- ☐ Complete the job shadow application packet and submit the application packet and proof of immunizations and TB results to jobshadowing@premierhealth.com at least **8 weeks** prior to requested shadowing date.

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

Job Shadow Application

Please provide all requested information and review and sign the documents to follow. Applicants under the age of 18 must have a parent/guardian to complete the documents to follow. Please complete the entire application accurately and honestly.

☐ High School Student ☐ College Student ☐ Professional

Date: _____

Name: _____ Age: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone (with area code): _____ Email address: _____

Emergency Contact Name: _____ Relation to Applicant: _____

Emergency Contact Phone Number: _____

Name of School / College Program: _____ Grade/Year: _____

Facility Requested: _____ Career of Interest: _____

Job Shadow Request Date(s): _____

Total number of hours Requested: _____ (20 max)*

* *Career / Technical or College Program students requiring multiple hours to meet application requirements for entry into career or college program may request up to 20 hours of shadowing.*

How did you hear about job shadowing at Premier? _____

Please submit completed application and supporting documents to jobshadowing@pemierhealth.com **8 weeks** prior to job shadow request date. Please allow **1-2 weeks** for the application to be processed. If your request cannot be fulfilled, an alternative option will be offered. Requests are accommodated based on availability of our Team members.

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.
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 attached Orientation Brochure that includes, but is not limited to, confidentiality, fire safety, infection control, and area specific requirements.
8. I understand that I am required to maintain verification of all immunizations, test dates, and test results, and that I must make those verifications available to Premier Health upon request.

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

_____ _____

Participant's Signature / Date Witness

_____ _____

Parent / Guardian Signature / Date Witness

HEALTH & LIABILITY FORM

Each Job Shadow applicant must complete this form and submit it to Premier Health for review prior to any Job Shadow Experience at Premier Health.

APPLICANT INFORMATION

Name: _____ Date of Birth: _____

HEALTH REQUIREMENTS

Verification of all test / vaccination dates and results MUST be maintained by Applicant or Applicant's Parent or Guardian and be made available to Facility within forty-hours (48) hours of a written request.

By completing the following, Applicant or Applicant's Parent or Guardian certifies that the following information is true and accurate.

Tuberculosis (TB) Testing

1. *Testing Requirement*: A baseline negative screen (A-D below) such as a Two-Step TB test anytime in the past; **OR** One-Step test AND dates of annual screenings; **OR** QuantiFERON® - TB Gold In-Tube test (QFT-GIT); **OR** T-SPOT® TB Test.
2. *Screening Requirement*: A current Negative TB Screening questionnaire is required (separate document provided)

A. Two-Step Mantoux Testing (Tuberculin Skin Testing/PPD)

Date of Step #1: _____ Results: _____
Date of Step #2: _____ Results: _____

OR

B. One Step Mantoux Testing (Tuberculin Skin Testing/PPD)

Date of Step #1: _____ Results: _____
Dates of Annual Screenings: _____

OR

C. QuantiFERON® - TB Gold In-Tube test (QFT-GIT)

Date of Test: _____ Results: _____

OR

D. T-SPOT® - TB test (T-Spot)

Date of Test: _____ Results: _____

If PPD skin test is positive: A chest x-ray report within the last 12 months **OR** a negative Interferon Gamma Release Assay (IGRA) - QuantiFERON®-TB Gold In-Tube test (QFT-GIT) **OR** T-SPOT®.TB test (T-Spot).

Date of Chest X-Ray: _____

COVID-19 Vaccination

Requirement: Full COVID-19 vaccination series

Type of Vaccination Administered: _____
Date of Dose #1: _____
Date of Dose #2 (if applicable): _____

Rubella and Rubeola Titer

Requirement: Documentation of serologic immunity **OR** 2 documented MMR (Measles, Mumps, Rubella) vaccines

Date of MMR Titer: _____ Results: _____

OR

Date of MMR Vaccination #1: _____

Date of MMR Vaccination #2: _____

Varicella/Varicella Titer/Varicella Vaccination

Requirement: A positive VZV (Varicella IGG) titer **OR** documentation of two immunization doses

Date of Varicella Titer/Varicella Exposure: _____ Results: _____

OR

Date of Varicella Vaccination #1: _____

Date of Varicella Vaccination #2: _____

Hepatitis B Vaccination

Requirement: A complete Hepatitis B vaccination series (3 shots) **OR** and a Hepatitis B surface antibody titer showing immunity

Date of HepB Vaccination #1: _____

Date of HepB Vaccination #2: _____

Date of HepB Vaccination #3: _____

OR

Date of Hepatitis B surface antibody titer: _____ Results: _____

Tetanus, Diphtheria, Pertussis (Tdap) Vaccination

Requirement: 1 Tdap dose or Tdap booster shot within last 10 years

Date of Tdap Vaccination (within last 10 years): _____

Annual Influenza Vaccination (October through March)

Requirement: 1 dose annually

Date of Vaccination: _____

Exemption from Any Requirement Listed Above (if applicable)

Requirement**:** Students must submit proof of approved exemption from any requirement listed above.

Exempt Requirement(s): _____

HEALTH INSURANCE REQUIREMENTS

Name of Company: _____

Policy Number: _____ Expiration Date: _____

Member Name: _____

STUDENT 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**

COVID-19 Assumption of Risk and Waiver

I, _____, wishing to participate in an educational experience at Miami Valley Hospital, Atrium Medical Center, and/or Upper Valley Medical Center (collectively the "hospital") hereby acknowledge that the hospital has implemented certain policies, procedures, and processes to protect its workers, patients, visitors, and volunteers from the acquisition and spread of COVID-19. To this extent, I agree to follow all hospital policies, procedures, and process as well as any Center of Disease Control (CDC) and local public health guidelines to reduce the likelihood of acquiring or spreading of COVID-19.

I attest that I do not believe that I have been exposed to a person with a confirmed or suspected case of COVID-19 and will not participate in an educational experience if I have been exposed to such individual for fourteen (14) days after the exposure and am not experiencing or have not within the past fourteen (14) days experienced COVID-19 symptoms. I also attest that I have not been diagnosed with COVID-19 and not yet cleared as noncontagious by a physician. I attest that the following will remain true for the duration of my educational experience with hospital.

I understand that I will be screened for COVID-19 symptoms upon arrival to the hospital. I agree to utilize a mask that has been provided to me or approved for use if brought from home. I agree to use proper hand hygiene which includes washing or sanitizing my hands after using the restroom, sneezing, coughing, and regularly throughout the day.

Assumption of Risk and Waiver of Liability

I acknowledge that I have voluntarily applied to the hospital's educational experience program. I understand that there is no compensation or direct medical health coverage afforded to me during my relationship with the hospital and the hospital is not responsible for any potential exposure to COVID-19. Due to the nature of COVID-19, I understand that even if I follow all policies, procedures, and processes I still may be exposed to COVID-19 and I may acquire COVID-19 through my participation in a program at hospital.

I fully understand and appreciate the risks that are inherent to my activities at the hospital, including but not limited to the risk of exposure to COVID-19. I hereby assume the risk of bodily injury, illness, and death resulting from my activities even if resulting from the negligence of the hospital or its employees, volunteers, patients, or visitors. I understand that certain inherent factors may make me more susceptible to acquiring COVID-19 or may increase the likelihood of severe symptoms including death if I contract COVID-19, and I have taken such factors into consideration and discussed any concerns with my physician(s) prior to participating in an educational experience at the hospital.

I hereby release, discharge and agree to indemnify and hold the hospital harmless from, and waive on behalf of myself, my heirs and successors, any and all causes of action, claims, demands, damage, costs, expenses and compensation or loss to myself that may be caused by any act, or failure to act of the hospital, or that may otherwise arise in any way in connection with any activities with, or at hospital.

I understand that this release discharges the hospital from any liability or claim that I may have against hospital with respect to any bodily injury, illness, or death that may arise from or in connection with my educational activities.

This liability waiver and release extends to the hospital together with all its Board of Directors, all parent or member entities and their Board of Directors, all affiliated entities and their Board of Directors, and employees.

By signing below, I voluntarily agree to comply with the written instructions above and the assumption of risk and waiver of liability. Failure to comply with these written instructions or verbal instructions from staff may result in my privileges being removed and I may be asked to leave the premises

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

Tuberculosis (TB) Screening Health Questionnaire/ Risk Assessment

Student's Name: _____ Job Shadowing Facility: _____

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)

ORIENTATION CHECKLIST

Review the information in the Orientation Brochure provided to you. When complete, initial each of the boxes below. Doing so indicates that you read and understood the information presented.

ITEM OF REVIEW:	PARTICIPANT INITIALS:	PARENT/GUARDIAN INITIALS (IF APPLICABLE):
Participant Responsibilities		
Premier Health Mission, Vision, & Values		
Patient Experience		
Cell Phone Usage		
Patient Rights		
Emergency Numbers, Safety Codes, & Your Role		
Infection Control – Hand Washing & Isolation		
Infection Control – Biohazard Waste & Hazardous Spills		
Infection Control – Protection Yourself & Exposure Info		
Confidentiality/HIPAA Info (Information in form attached)		

I agree that I have reviewed the information in the Orientation Brochure as indicated above by my initials. I know that if anything comes up that was not covered within, I can go to my preceptor, the manager of the department I am in, or to a member of the Learning Institute with any questions/concerns.

Participant Signature: _____ **Initials:** _____ **Date:** _____

Parent / Guardian Signature: _____ **Initials:** _____ **Date:** _____
(If participant is under the age of 18)

JOB SHADOW ORIENTATION BROCHURE CONTENT REVIEW (Answer each question.)

1. Premier Health's Core Values include:
   - ☐ a. Respect, Interest, Compassion, Excellence.
   - ☐ b. Responsibility, Interest, Compassion, Excellence.
   - ☐ c. Respect, Integrity, Compassion, Excellence.
   - ☐ d. Responsibility, Integrity, Compassion, Excellence.
2. Premier Health's Patient Experience expectations:
   - ☐ a. Safety.
   - ☐ b. Quality.
   - ☐ c. Service.
   - ☐ d. All of the above.
3. Any patient information must be kept confidential.
   - ☐ a. True
   - ☐ b. False
4. Two important factors in response to a code or emergency at any Premier facility are what code is being announced and location of the code.
   - ☐ a. True
   - ☐ b. False
5. I have reviewed and understand all of the content in the Premier Health Orientation Brochure. I will adhere to the guidelines provided.
   - ☐ a. Yes, I will.
   - ☐ b. No, I will not