Job Shadowing Application

CHI Saint Joseph Health

Please complete all fields **on a computer** prior to submitting. Incomplete applications will not be accepted.

Student Information

Date:		
Student First Name/Nickname:		
Student Middle Name:		
Student Last Name:		
Student Email Address:		
Student Home Address:		
City:		
State:		
Zip Code:		
Student Cell Phone:		
Gender:		
Grade Level:		
Date of Birth (mm/dd/yyyy):		
Age:		
Employed at CHI Saint Joseph Health?	Yes ☐	No ☐
Volunteering at CHI Saint Joseph Health?	Yes ☐	No ☐

School Information

Current School Attending:	
Level of Education Obtained:	
Major/Degree:	
Anticipated Graduation Date:	

Job Shadowing Preferences

Department Sponsor Name/Signature:	
Department/Unit Where Observation Will Occur:	

Observation Date(s) & Time

Proposed Date(s) of Observational Experience	
Proposed Hour(s) of Observational Experience	

The total shadowing experience is for a minimum of 2 hours and no more than 40 hours within a 1 month period.

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Preferred Location

Location choice:	Choose from our Locations
	Flaget Memorial Hospital
	Saint Joseph Berea
	Saint Joseph East
	Saint Joseph Hospital
	Saint Joseph Jessamine
	Saint Joseph London
	Saint Joseph Mount Sterling
	Women's Hospital at Saint Joseph East
	Continuing Care Hospital
	CHI Saint Joseph Health Medical Group
	Other (please specify):

Job Shadowing Participation Agreement

CHI Saint Joseph Health

HIPAA Confidentiality Agreement

I have read the above information and I understand what it means to me as a Job Shadower. I understand the importance of maintaining the privacy of all confidential medical information I may encounter during the course of my job shadowing experience and agree to maintain patient confidentiality. I recognize that I may be exposed to potential risks as a result of this activity and will not hold CHI Health liable for any risks as a result of this activity.

_____	_____	_____
Print Student Name	*Signature of Student*	*Date*

Parental/Guardian Participation Consent

_____ has my permission to participate in the job shadowing experience offered by CHI Saint Joseph Health. I have reviewed the terms of this confidentiality agreement with my child, stressing the importance of maintaining the privacy of all confidential medical information he/she may encounter during the course of his/her job shadowing experience. I recognize that job shadowing offers a significant benefit to my child in terms of first-hand exposure to potential career opportunities in the medical field. In consideration for this benefit, I agree to hold harmless and indemnify CHI Saint Jospeh Health from any liability arising from my child's failure to abide by CHI Saint Joseph Health's policies concerning the privacy of confidential medical information.

_____	_____	_____
Print Parent/Guardian Name	*Signature of Parent/Guardian*	*Date*

Participant Agreement

As a participant in the CHI Saint Joseph Health Job Shadowing program:

1. I will not touch the patients. If I am allowed to observe a patient having a procedure, I understand the director or manager is to obtain the patient's consent first.
2. I will not touch medical equipment.
3. I understand that I do not have medical record or chart access and will not have computer access.
4. I will not assist in feeding but may help deliver food.
5. I will not approach physicians about personal illness or medications.
6. I will dress professionally as outlined in the policy.
7. I am subject to CHI Saint Joseph Health's drug testing policy. If I object, I will be asked to leave the premises immediately.
8. I understand CHI Saint Joseph Health is not held responsible for any accident or injury that may occur on its premises while shadowing.
9. I understand that I am to leave all valuables at home.
10. I understand that any use of a cellular device is prohibited.
11. I will not perform my own personal care in the clinical setting (i.e. applying lip gloss, handling contact lenses, eating or drinking, brushing hair, etc.)

Job Shadowing Participation Agreement (Cont.)

CHI Saint Joseph Health

12. I will not be permitted in areas of contamination such as isolation rooms, soiled linen areas, neonatal intensive care, burn unit, behavioral and autopsy room.
13. I understand that I cannot participate in the program on days that I am ill. These include but are not limited to: fever, diarrhea, productive cough, rash, or open wound.
14. I understand that I will be required to sign a HIPAA Privacy, Security and Confidentiality Agreement wherein I agree to keep all patient information confidential. Failure to comply may result in dismissal.
15. I understand that CHI Saint Joseph Health will have the right to immediately terminate my participation in the program if it is determined at the manger or supervisor's discretion that I am not acting in the best interest of the patient or facility. In addition, the director or manager holds the right to terminate shadowing at any point if deemed necessary.

Job Shadowing Participant Agreement

_____
Print Student Name

_____ _____
Signature of Student *Date*

_____ _____
Signature of Parent/Guardian *Date*

Consent for Emergency Treatment

In the case of an injury while participating in career exploration activities at CHI Health, I give my consent for CHI Health, its physicians, employees and agents to render emergency and other necessary medical treatment. I, _____ *(Print Parent/Guardian Name),* release CHI Health, its physicians, employees and agents from any costs associated with rending of treatment to the minor that is necessary in an emergency.

_____ _____
Parent Signature *Date*

_____ _____
Student Signature *Date*

Emergency Contact Information

Please print the name and contact information of an individual who should be contacted in the event of an emergency.

Name _____ Relationship _____

Home Phone _____ Work Phone _____

Cell Phone: _____

Email Address: _____

Your Goal

Please share what you hope to gain from this experience: