CHI Saint Joseph Health

COVID Training Review Sheet

Print Name: _____ DOB: _____ Date: _____

Primary Location:

☐ Flaget Memorial Hospital ☐ Saint Joseph Hospital ☐ Saint Joseph Mount Sterling

☐ Saint Joseph Berea ☐ Saint Joseph Jessamine ☐ Other _____

☐ Saint Joseph East ☐ Saint Joseph London

Please read each statement. Circle **True** or **False** as your answer.

1. I will be required to wear a mask to enter any CHI Saint Joseph Health facility and wear it continuously while in the facility. True / False

2. I realize that I must be screened and logged each time I arrive to job shadow. True / False

3. I agree that these are important precautions. As a job shadower or non-employee, I understand that I am a representative of CHI Saint Joseph Health and an advocate of these efforts to keep our community safe. True / False

I have read the COVID-19 training and fully understand the contents. I agree to follow the requirements as outline. I understand that there is an inherent risk in job shadowing just as there is a risk in interacting with others in any public setting and am willing to accept this risk. I will fully cooperate in any contact tracing and requested COVID testing should that be deemed necessary. Further, I recognize that should I become COVID positive, I am responsible for all costs of treatment.

SIGNATURE: _____

If a job shadower is a minor – below must be completed by the legal parent/guardian.

As the parent/guardian of the above named minor, I confirm that I have read the COVID-19 training and fully understand the contents as it pertains to my son/daughter/charge. I agree to the requirements as outlined. I understand that there is an inherent risk in job shadowing just as there is a risk in interacting with others in any public setting and grant permission for my son/daughter/charge to resume job shadowing. I will ensure full cooperation in any contact tracing and/or requested COVID testing should that be deemed necessary. Further I recognize that should my son/daughter/charge become COVID positive that I am responsible for all costs of treatment.

SIGNATURE: _____ **DATE:** _____

PRINT NAME: _____

Revised: 03/2/21