Bryan GRAND ISLAND Regional Medical Center

**Job Shadowing Form**

| | |
|---|---|
| Date | |
| First Name | |
| Last Name | |
| Address | |
| City | |
| State | |
| Zip Code | |
| Date of Birth ***Must be 16 and older to apply for job shadowing**** | |
| Email Address | |
| Cell Phone Number | |
| Date of Shadowing Experience ***Required**** | |
| End date of Shadowing Experience | |
| First name of Provider | |
| Last name of Provider | |
| Additional Dates | ☐ Yes ☐ No |
| School attending | |
| Grade Level | |
| Program Major | |

**Departments of Interest (list 1st, 2nd, and 3rd choice):**

_____ Environmental Services

_____ Health Information

_____ Lab/Pathology

Nursing (select area of interest):

_____ Cardiology/Interventional Radiology

_____ Emergency Department

_____ Intensive Care Unit

_____ Labor & Delivery

_____ Med-Surg

_____ Neonatal Intensive Care Unit

_____ Progressive Care

_____ Nutritional Services

_____ OR/Surgical Services (per policy must be 19 to observe in this area)

_____ Physical/Occupational Therapy

_____ Pharmacy

_____ Radiology

_____ Respiratory

_____ Social Work

_____ Provider ( **Note: It is your responsibility to arrange shadowing directly with providers. We do not do this for you. Consider asking your primary provider or contact a specialty provider group that interests you.)**

_____ Other Preference: _____

**Your Goal** (Please share what you hope to gain from this experience):

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# CONFIDENTIALITY STATEMENT

It is the policy of the hospital to respect and protect the privacy rights of patients, their families, staff and third parties. ALL information contained in medical records, staff files, computer banks/systems and hospital records of any kind is strictly confidential. In addition, any information about the hospital's business, patients, families, staff or third parties (and/or agents of) which is disclosed or becomes known in the course of one's job must be kept confidential. This information must not be repeated or discussed with anyone outside of the direct care of the patient. Information must not be treated as gossip with fellow employees, nor disclosed to unauthorized sources outside Grand Island Regional Medical Center (GIRMC).

At times, I may be involved with information pertaining to patients and employees as well as physicians and other professionals. I will have the responsibility to assure the privacy and confidentiality of any information gathered and in reporting such information. I agree that I will not post or transmit any information related to the hospital, its medical staff, employees, workforce members, contractors, patients, patient families or other confidential information to any social networking site, website, blog, tweet or similar site or function.

Anyone who is authorized to access the electronic patient/resident/employee records will be issued a unique username and password. The use or disclosure of another individual's password or unauthorized accessing of past or present patient/resident or employee information are grounds for immediate corrective action.

The electronic information systems will list and record inquiries and transactions involving system access. This record includes: application/module, user, date/time/duration of inquiry, patient name and terminal location. Any knowledge of a breach of this policy is to be reported to the HIPAA Privacy Officer.

I further understand that GIRMC has policies and procedures to assure compliance with regulations under the Health Insurance Portability and Accountability Act. I agree to abide by all such policies and procedures. I further agree to immediately report to my supervisor, the HIPAA Security or Privacy Officer any suspected or actual unauthorized use, disclosure, acquisition or access to protected health information or any loss of a mobile device (laptop, smart phone, flash drive, disc, etc.) that contains PHI. I understand that violation of any breach of policies related to confidentiality or the GIRMC's Corporate Compliance Program or Code of Conduct may result in disciplinary action as stated in the policy "Progressive Discipline". Disciplinary action may include my immediate termination.

I have read and understand the above statements.

Print Name: _____

Signature: _____

**Participant Agreement:**

As a participant in the GIRMC 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 Dress and Grooming Standards.
7. I am subject to GIRMCs' drug testing policy. If I object, I will be asked to leave the premises immediately.
8. I understand GIRMC 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 preform my own personal care in the clinical setting (i.e. applying lip gloss, handling contact lenses, eating or drinking, brushing hair, etc.)
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, open wound, or COVID symptoms (Fever or chills, cough, shortness of breath, fatigue, muscle or body aches, headache, loss of smell or taste, sore throat, congestion, runny nose, nausea, vomiting, diarrhea, trouble breathing, persistent pain or pressure in the chest, new confusion).
14. I understand that I am 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 GIRMC will have the right to immediately terminate my participation in the Job Shadowing program it is determined at the manager 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:**

| | |
|---|---|
| Printed Student Name | |
| Signature of Student | |
| Signature of Parent/Guardian | Date |

**Consent for Emergency Treatment**

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

Parent/Guardian Signature: Date:

Student Signature: Date:

**Emergency Contact Information**

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

Name: _____

Relationship to applicant: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email Address: _____

**Parental/Guardian Participation Consent:**

If student is younger than 19, a parent or guardian's signature is required:

(Student Name)_____has my permission to participate in the job shadowing experience offered by GIRMC. 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 GIRMC from any liability arising from my child's failure to abide by GIRMC policies concerning the privacy of confidential medical information.

| | Date(s) of Immunization: |
|---|---|
| · DPT/Tdap (Diphtheria, Pertussis, Tetanus) | |
| · Influenza (Flu Shot - October through March) | |
| · Hepatitis B (One Completed Series) | |
| · MMR (Measles, Mumps, Rubella) | |
| · COVID- Primary Series or Request Declination Form | |
| · Varicella (Chicken Pox) | |
| Print Parent/Guardian Name | |
| Signature of Parent/Guardian | |

**Please submit completed forms to girmc_education@bryanhealth.org upon completion.**