Job Shadow Application

Thank you for your interest in the Regional West Shadow Experience Program. We are excited that you are interested in a possible career in the medical field. If you are 16 years of age or younger, please complete this form with a parent's signature. You may deliver the application to Regional West by dropping it off at the Employee Support Services Desk, emailing linda.alfred@rwhs.org or faxing it to 308-630-1792.

Name: _____ Date of Birth: _____

Age: _____

High School Graduation Year: _____

School or College: _____

Home Address: _____City, State, Zip:_____

Phone Number: _____Email Address: _____

What jobs or departments are you in interested in shadowing?

1st Choice: _____

2nd Choice: _____

3rd Choice: _____

Why do you wish to shadow in these areas?

_____

_____

Do you have a health care professional in mind with whom you like to shadow?

_____

What do you hope to learn from the experience?

_____

Please list three dates at least two weeks from now (in order of preference) that you wish to shadow. If only specific hours work on these days, please note that as well. If unsure of possible shadowing dates, leave blank and contact us later with definite dates.

1._____ 2. _____ 3. _____

Number of shadowing hours desired: _____

(If you need hours tracked, please provide the necessary form.)

Signature: _____

Job Shadow Agreement and Authorization to Participate

1. Waiver of Liability. In consideration that I am being permitted to participate in Regional West Health Services' workforce development program (e.g., job shadowing, observations, activities, etc.), I, undersign, in full recognition and appreciation of the dangers and hazards inherent in this activity, agree to assume all risks and responsibilities surrounding my participation in this activity. Further, I do for myself, my child/children, my heir and personal representative(s) agree to defend, hold harmless, indemnify, release, and forever discharge Regional West Health Services, and its officers, agents, and employees from and against any and all future claims, demands, or causes of action, on account of damage to personal property, personal injury or death which may result from my participation in any Regional West Health Service career–related program.
2. No Cell Phones. I understand while job shadowing at Regional West Health Services, any usage of cellular devices are prohibited. All patient information and results must be kept confidential and may be report only to those professionals directly involved with the patient's treatment and care. Failure to comply may result in dismissal from the site.
3. Confidentiality. I agree that I shall not, at any time during the job shadow or after it has concluded, divulge or convey any confidential information, trade secrets, business plans, proprietary information, knowledge, data or property related to Regional West Health Services or any of its affiliates or patients other than that which is in the public domain, unless authorized by Regional West Health Services in writing. This specifically means that I may not share details about the program or any patients (or their families) that I may come into contact with in any social media form, such as Facebook, Instagram, SnapChat, etc. In the event of any violation or threatened violation of this section, Regional West Health Services shall be entitle to immediate injunctive or other equitable relief in addition to any other remedies to which Regional West Health Services may be entitled to under law.
4. HIPAA. The Health Insurance Portability and Accountability Act (HIPAA) was enacted by Congress in 1996. HIPAA specifically protects the confidentiality of each individual's health information, and provides criminal penalties and fines for persons that breach that confidentiality. The job shadow program will place you in a medical environment and you will be personally responsible for complying with HIPAA; failure to do so may/will result in criminal prosecution. You understand you are required to receive necessary HIPPA training as directed by Regional West Health Services and you are responsible for following all policies and expectations of any employee. You may find more information about HIPAA and your responsibilities at www.hhs.gov/hipaa/.
5. No Entitlements to Benefits or Wages. I understand that I am not an employee of Regional West Health Services or any of its subsidiaries or affiliates, and am not entitled to any wages or benefits, including, but not limited to: social security benefits, workers' compensation benefits, and retirement benefits.
6. Responsibility to Cover Costs. I understand and agree that I am solely responsible for any costs that I may incur by participating in the job shadowing program. These costs may include, but are not limited to: health screening, transportation, meals, and parking.
7. Compliance with Law / Policies. I understand and agree to abide by any and all applicable laws, regulations, and policies adopted by Regional West Health Services, including the Code of Ethics.
8. Deadlines. I understand the submission of the job shadow application must be minimum of 14 days PRIOR to the desired start date of the experience. I also understand it may take two to three weeks to arrange a schedule to shadow.
9. Dates. The expected start date of shadowing is _____.
10. Health Insurance / Exposure to Infectious Agents. I understand that the job shadow program will take place in a medical facility and that I may be exposed to infectious agents including blood borne pathogens. I hereby represent and warrant that I have health insurance and agree to be liable for any charges for services I may receive related to emergency care and/or testing to determine exposure to infectious agents. I understand that Regional West Health Services will/may require certain immunizations prior to my experience and I will provide proof of such vaccinations, including the influenza vaccination.
11. Indemnification. I agree to indemnify and hold harmless Regional West Health Services, its subsidiaries, affiliates, officers, directors, agents, employees, and representatives ("Indemnified Parties" jointly and severally) from and against any and all liabilities or related, arising out of or in connection with the job shadow program, incurred by my wrongful acts, omissions, or misconduct. This shall be specifically construed to include, but not be limited to, any violation of the Health Insurance and Portability Act (HIPAA).
12. Acknowledgement. I have read the job shadow/observation request form for Regional West Health Services and hereby certify that all information provided in this request is accurate, and that submission of this request does not guarantee placement into an experience. I further understand that approval and placement of an experience is at the discretion of Regional West Health Services, and may require additional health screening. Regional West Health Services may terminate a job shadow at any time and for any reason.

Job Shadow Agreement and Authorization to Participate

HAVING READ AND UNDERSTOOD THIS AGREEMENT, I VOLUNTARILY AND KNOWINGLY SIGN BELOW

_____	_____	_____
Applicant Name	Applicant Signature	Date

Permission of Parent (required of any student under the age of 19)

I grant my child, _____, who is 16 years of age or older, permission to participate in the approved Regional West Health Services Shadow Experience. I understand that he/she may be exposed to patient information and that he/she is responsible for keeping it confidential. I also recognize that he/she may be exposed to potential risks as a result of this experience and agree to not hold Regional West Health Services liable for any harm or injury as a result of this experience.

Parent/Guardian's Signature: _____

Date: _____

Job Shadow Confidentiality Statement

Regional West Health Services has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their health and financial information. Protected health information may include but is not limited to: names, dates of birth, diagnoses, pictures, and financial information. Remember, the mere fact that someone is in the facility is confidential! Just don't talk about it!

As a Shadow Candidate or Business Associate, I have received training, and understand and agree that I must hold all patient information in confidence. This includes the names of person(s) I may encounter while in the facility, and/or any information relating to that person(s). I am not to disclose any Protected Health Information (PHI) to any unauthorized source or person(s). This includes my family, spouse, children, and parents.

I understand that any breach of confidentiality is a violation of this agreement and that breach will result in me being barred from the facility as a Job Shadow Candidate in the future. Furthermore, I understand a violation may affect the Job Shadow Program and/or affiliation agreement for other students. I understand this document must be signed annually to ensure understanding and compliance.

In the event that a breach of confidence occurs by a Job Shadow Candidate, depending on the harm caused, the candidate and/or their parents (when applicable), may face legal charges. If you become aware of a breach of any Protected Health Information, please contact the Privacy Officer at 308.635.3711.

Signature: _____ Date: _____

Job Shadow Candidate

Expires: _____

Signature: _____ Date: _____

Regional West Health Services Representative

Job Shadow Immunization Requirements
(Copies of Documents Must be Attached to Qualify)

Name: _____Date Of Birth: _____
Start Date: _____End Date: _____Phone Number: _____
Department(s):_____

If available, please attach any vaccination records from childhood, school/college, military, state database (Nebraska dhhs.ne.gov/Nesiis), etc.

Students non-patient care (observation only) and Staff from other facilities (hands-on training)

1. Record of influenza vaccination during flu season (October 1 through May 31) date _____
or RWHS Exemption form (if exemption approved must wear mask in facility at all times from Nov-May):_____

2. Record of COVID vaccination(s)dates/types_____ _____ _____ _____
_____
Or I decline the Covid vaccination SIGNATURE_____DATE_____

3. TUBERCULOSIS (TB) SCREENING (please check appropriate boxes)
☐Temporary or permanent residence (for ≥1 month) in a country with a high TB rate (i.e., any country other than Australia, Canada, New Zealand, the United States, and those in western or northern Europe)
☐ Current or planned immunosuppression, including human immunodeficiency virus infection, receipt of an organ transplant, treatment with a TNF-alpha antagonist (e.g., infliximab, etanercept, or other), chronic steroids (equivalent of prednisone ≥15 mg/day for ≥1 month), or other immunosuppressive medication
☐ Close contact to someone with infectious TB disease during lifetime
☐ None of the above (no TB testing needed)

If Tuberculosis (TB) testing needed
Negative TB skin test within last 12 weeks date _____and Negative within last 12 months date: _____
OR Negative Quantiferon Gold TB lab test within last 12 weeks date_____.
[For those with previous positive TB testing, allergy to TB skin testing, immunosuppressive medications (ie. steroids), or receivers of BCG vaccine (only given outside of U.S.), TB lab testing (QTBG or Tspot) is preferred]

Staff from other facilities (hands-on training)

4. Attestation of Drug Test with date/results

5. Respirator fit testing needed if entering airborne precaution rooms (N-95 or PAPR for Covid, Chicken Pox, Shingles, Measles, Tuberculosis, Monkey Pox, etc.) or Chemotherapy preparation (PAPR)

6. Two Varicella vaccine doses dates#1_____#2_____OR Varicella IgG Positive/Negative date _____
(If neg, two doses are needed OR RWHS exempt form _____)

7. Hepatitis B antibody Positive/Negative date_____ (N/A if no patient contact)
If negative, record of 3 doses of vaccine #1 #2 _____ #3 _____
Then re-titer If still negative, record of booster #4
Then re-titer If still negative, record of 2 more doses #5 #6
Then re-titer If still negative, non-converter after 6 max doses
Or vaccine declination signed_____

8. Two MMR vaccine doses #1_____#2_____
OR Measles IgG Pos/Neg date_____Mumps IgG Pos/Neg date _____Rubella IgG Pos/Neg date _____
(If neg, two doses are needed OR RWHS exempt form _____)

9. Tetanus, diphtheria, and pertussis (Tdap) vaccination (q10 yrs) date
OR RWHS exempt form_____

_____ _____
Signature/Print Name Date