GUNDERSEN HEALTH SYSTEM®

JOB SHADOW APPLICATION

This form is required for individuals requesting to job shadow or observe at Gundersen Health System. Upon submission, this application will be reviewed and you will be notified via email if your request has been accepted or declined. If you have any questions regarding this form, please contact GHSJobShadows@gundersenhealth.org . This form (and accompanying forms) should be submitted **30 days prior** to your requested observation dates.

Participant:

Name _____ **Age**_____

Phone Number _____ **Email:** _____

Name of Current School/College _____ **College Major**_____

Are you a current GHS employee or volunteer? [X] _____ Yes _____ No

Are hours required for your education? [X] _____ Yes _____ No

If yes, how many hours do you need:_____

Please provide your top three areas of interest (ie. department and/or position) in order of preference:

Area(s) of interest _____

Area(s) of interest _____

Area(s) of interest _____

Have you contacted someone at GHS who is willing to mentor you? [X] ____ Yes ____ No

If yes, please provide their name here: _____

Please indicate your availability below [X]:

Days: _____Mon _____Tues _____Wed _____Thurs _____Fri

Time of Day: Morning _____ Afternoon _____

Specific Date(s): _____

Emergency Contact Information

Name: _____ Relationship _____

Phone Number: _____

I represent that information provided in this application and all other forms is accurate and complete. I understand that a condition of this application is that any misrepresentation, misstatement, or omission from this application, whether intentional or not, is cause for automatic and immediate rejection of this application and may result in the denial of further shadows at Gundersen Health System.

_____ _____

Signature of Participant **Date**

_____ _____

Signature of Parent/Guardian of Minor (if applicable) **Date**

All decisions with regard to shadows or observations will be at the discretion of Gundersen Health System designated representatives.

Please email all completed documents to GHSJobShadows@gundersenhealth.org.

Do not assume a request has been approved until you have **received confirmation** from Gundersen Health System.

Job Shadow Agreement Form

PLEASE READ THIS SECTION CAREFULLY BEFORE SIGNING. (If a minor, a parent or legal guardian's signature is mandatory.)

This form (and accompanying forms) will be submitted **30 days** prior to your requested shadow dates.

I. I, _____, have requested Gundersen Health System to grant permission for me to be present in the hospital, nursing home, home health, or hospice setting for a job shadow to enhance my education.

In return, I, the Job Shadow Participant, agree to adhere to the following rules:

a. I will read Gundersen Health System's Job Shadow/Observation GL-9932 policy and adhere to the policy. I will ask questions if I do not understand the policy.

b. I will notify GHSJobShadows@gundersenhealth.org if I need to cancel the job shadow experience.

c. I will wear business casual clothing to the site. This includes closed toe shoes and socks unless otherwise informed.

d. Perfume/colognes may trigger allergic reactions in patients, therefore should be minimal.

e. At no time will I represent myself as a member of the health care workforce at this site.

f. I will wear personal protective equipment when warranted or as directed.

g. I will wear the badge provided to me identifying myself as a student. The badge must be worn above the waist and returned promptly after the shadow is complete.

h. I will inform my mentor if at any time I feel nauseous, dizzy or otherwise ill during the shadowing activity.

i. I will arrive promptly and remain flexible to allow for extenuating circumstances such as patient emergencies that might interrupt the schedule.

j. Cell phones must be turned off during the shadow experience.

k. I will follow all directions given by Gundersen Health System.

II. I understand the patient/resident's right to confidentiality and agree to respect that right by not disclosing information regarding any patient/resident or regarding the organization/administration. I have also read, understand, and signed the Gundersen Health System's Confidentiality and Security of Information HR-205 policy.

III. I recognize that shadowing in the health care setting and any complication thereof may be emotionally distressing. I also recognize the primary responsibility of Gundersen Health System staff is to the patient; therefore, it may not be possible to provide immediate attention to me should the need arise.

IV. I understand that if permission is granted, it may be revoked at any time.

V. I hereby release Gundersen Health System and affiliates from any claims and/or liability, physical injury and/or damage including emotional distress which may be sustained by me as a result of the presence of myself in the hospital, nursing home, home care, or hospice setting.

VI. I am age 16 or older.

Signature of Participant **Date**

Signature of Parent/Guardian of Minor **Date**

Please email all completed documents to GHSJobShadows@gundersenhealth.org

Updated 7/10/24

GUNDERSEN
HEALTH SYSTEM®

CONFIDENTIALITY STATEMENT

It is the policy of GUNDERSEN to respect and protect the right to confidentiality and privacy of all patient and Staff concerning their health care, personal, or employment information. All Staff is responsible to maintain the confidentiality of this information protecting it against loss, defacement, tampering, access, or use by unauthorized individuals.

Confidential Information: Verbal communications, written records, computer-based information, other electronic, visual or digital media, photography, films and observations including but not limited to:

Individually Identifiable Health Information: Information, including demographic information, that is created or received by a health care provider and relates to the past, present, or future physical or mental health or condition of an individual The information either identifies the individual or there is a reasonable basis to believe the information could be used to identify the individual.
Health Care Information: All information and records, in any form, related to the physical or mental health of a patient prepared by or under the supervision of a health care provider, e.g., diagnosis, treatment, prognosis, condition, or other information contained in medical records, photographs, video tapes, or verbal reports.
Personal Information: Patient birth date, address, phone number, admission and discharge dates, appointment or visit dates, doctor's name, family or social information, financial information.
Employment Information: Employee address, birth date, telephone number, personnel file, job application, performance appraisal, discipline, termination, investigations, compensation and benefits.
Business Information: Confidential business information is information of a proprietary nature related to the operations, finances, marketing or strategic plans, or internal performance measurement of GUNDERSEN. Proprietary information obtained through verbal or written internal communication is ***confidential*** unless it is made public through Administration or Marketing Services. Such information may include ***but is not limited to*** trade secrets, pricing strategies, market penetration information, marketing or promotional plans, staff recruiting or retention strategies, quality or satisfaction ratings, patient/customer complaints or feedback, or terms of contracts.

My signature below affirms my personal understanding and signifies that I:

- Understand that access to confidential information is limited to authorized users, based on their **job related need-to-know**.
- Recognize GUNDERSEN's commitment to confidentiality and privacy,
- Realize that breaches of patient confidentiality can result in disciplinary action up to and including termination of employment,
- Assume responsibility for contacting the Legal Department if I become aware of unauthorized access or inappropriate handling, use or sharing of confidential information,
- Have read and understand GUNDERSEN Policy HR 205 "Confidentiality and Security of Information".

Signature: _____ Date: _____

Print Name: _____ Employee Number: _____

Department or School: _____

Job Shadow Health Screening Form

Completed Health Screening Form must be received a minimum of 30 days prior to your experience.

Name *(Last, Middle Initial, First)* _____ Date of Birth _____

Attach proof of immunization records OR have health care provider sign below verifying your information. You MUST provide medical documentation of vaccination or titer OR disease history OR combination for each of the following:

Required Information	REQUIRED Immunization Dates (Month/Day/Year)	
Measles (Rubeola)		
Mumps		
Rubella		
Chicken Pox (Varicella)		
Annual influenza vaccine (current season) - **Starts Oct 1 - Ends May 31**		

*Any cost incurred to update immunizations or obtain immunization information will be the responsibility of the job shadow participant.

*****Job Shadows WILL NOT BE CONSIDERED without proof of ALL VACCINATIONS above. NO EXEMPTIONS will be given.*****

_____	_____	_____	_____
Health Care Provider Signature	Date	PRINT Health Care Provider Name	Health Care Provider Phone

My signature confirms that the above information is true. At the time of my signature below, I confirm that I am free of any communicable diseases and I do not have a cough, fever, etc. If any symptoms arise prior to my time at Gundersen Health System, I will notify GHSJobShadows@gundersenhealth.org immediately of my current situation.

Signature of Participant:_____ Date:_____

Signature of Parent/Guardian of Minor (if applicable):_____ Date:_____

If you have questions, please email GHSJobShadows@gundersenhealth.org. Please send all completed documents to GHSJobShadows@gundersenhealth.org.

Updated 7/10/24