



Job Shadow Application

University of Michigan Health-West Use

Dept Assigned: _____
Date & Time Assigned: _____
With Employee: _____
☐ Application
☐ Confidentiality Agreement
☐ Health Screening

Today's Date: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Preferred Phone: _____ Date of Birth: _____

Home Address: _____

City: _____ State: _____ ZIP: _____

Email Address: _____

In case of an emergency, contact: Name: _____ Relationship: _____

Phone: _____

Name of School/Company: _____

Grade (if applicable): ☐ 9th ☐ 10th ☐ 11th ☐ 12th
☐ college/trade school

Days available for job shadow experience: ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri

Times available for job shadow experience: ☐ Morning ☐ Afternoon

Or, list specific dates and times you are available: _____

Job/Area of interest: 1st Choice: _____ 2nd Choice: _____

(Please Note: Emergency, ICU, and Labor & Delivery are not available)

Why are you requesting this shadow experience? What do you expect to learn?

I have read and understand the information on the Information Sheet. Should I need medical attention during or as a result of this job shadowing experience, I assume full responsibility for any treatments deemed necessary. I assume responsibility of all medical costs which result and release University of Michigan Health-West of all liability. I give the facility at which the job shadow is being conducted permission to release my telephone number or contact instructions to the requested department. While I am job shadowing at any site under University of Michigan Health-West, I realize that all healthcare information, patient/resident care and records are a confidential matter. All information exchanged while I am observing must be held in strictest confidence.

Applicant Signature: _____ Date: _____

I have read and understand the information on the Information Sheet and authorize my child to participate in this job shadowing experience. University of Michigan Health-West shall not be held responsible for adverse occurrences and/or outcomes. Should my child need medical attention during or as a result of this job shadowing experience, I authorize such medical care and assume full responsibility for any treatments deemed necessary. I assume responsibility for all medical costs which result and release University of Michigan Health-West of all liability. I give University of Michigan Health-West permission to release my child's telephone number or contact information to the requested department.

Parent Signature: _____ Date: _____
(if applicant is under the age of 18)

For All Job Shadows (excluding Nursing), please submit application to:
University of Michigan Health-West
Attn: Jennifer DeVries, Volunteer Services
PO Box 916
Wyoming, MI 49509
Email: jennifer.devries@umhwest.org
Phone: 616.252.7009 ■ Fax: 616.252.0120

For Nursing Job Shadows, please submit application to:
University of Michigan Health-West
Lisa Dewhurst-Walker, Nursing Administration
PO Box 916
Wyoming, MI 49509
Email : lisa.dewhurstwalker@umhwest.org
Phone: 616.252.5115

Confidentiality Acknowledgment for Job Shadowing

This Confidentiality Acknowledgment (the "Acknowledgment") is entered into by the individual signing below ("Participant") in consideration of participating in a job shadowing/learning experience at University of Michigan Health-West ("UMHW").

1. *Purpose of Acknowledgment:* The purpose of this Acknowledgment is to protect UMHW's confidential information during Participant's Job Shadowing/Learning experience. The Participant agrees to maintain the confidentiality of any and all information obtained or disclosed during their presence at UMHW.
2. *Confidential Information:* Confidential information includes but is not limited to patient records, medical history, test results, treatment plans, diagnoses, proprietary information, trade secrets, financial information, business operations, strategies, policies, procedures, and any other information disclosed to or observed by the Participant during their Job Shadowing/Learning experience.
3. *Obligations of the Participant:*
 - a. Non-Disclosure: The Participant agrees not to disclose, directly or indirectly, any confidential information to any third party without the prior written consent of UMHW. This obligation continues even after the termination of the Job Shadowing program or the Acknowledgment.
 - b. Use of Confidential Information: The Participant agrees not to use any confidential information obtained or observed during the Job Shadowing/Learning experience for personal gain or any other purpose other than the intended educational and observational purposes.
 - c. Duty of Care: The Participant shall exercise reasonable care to protect the confidentiality and security of the confidential information.
4. *Return of Materials:* Upon the completion of the Job Shadowing/Learning experience or at the request of UMHW, the Participant agrees to return all materials, documents, notes, or any other tangible or electronic form of confidential information obtained during their presence at UMHW.

ACKNOWLEDGED AND AGREED TO BY:

Participant:

Participant's Full Name

Participant's Signature

Date

Job Shadow Health Screening

COMPLETE and RETURN form prior to the job shadow experience.

Job Shadow Participant (printed name): _____

University of Michigan Health-West Shadowing Location: _____

HEALTH RELATED REQUIREMENTS	Vaccination Dates	Test Dates & Results (TB test, lab titers, chest x-ray with history of positive TB test)	Other (Details, history or exempt due to date of birth)
TB Screening <input type="checkbox"/> Proof of a negative TB test <u>within the past year</u> OR <u>If you have not a TB test within the past year</u> , complete the following:	Not Applicable		
Please check YES or NO to the following questions. Give details in "Other" column for any "Yes" answers. Anyone who currently is symptomatic ("Yes" answers to items A-F) may not job shadow until symptom free and cleared by their physician.			
In the <u>past year</u>, have you had: A. Unaccountable weight loss <input type="checkbox"/> Yes <input type="checkbox"/> No B. Onset of chronic cough <input type="checkbox"/> Yes <input type="checkbox"/> No C. Coughing up of blood <input type="checkbox"/> Yes <input type="checkbox"/> No D. Chest pain on breathing <input type="checkbox"/> Yes <input type="checkbox"/> No E. Night sweats <input type="checkbox"/> Yes <input type="checkbox"/> No F. Unaccountable fever <input type="checkbox"/> Yes <input type="checkbox"/> No G. A chest x-ray <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, detail when and why you had the x-ray in "Other" column.			
Rubeola and Rubella (<i>If born in or after 1957</i>) <input type="checkbox"/> 2 MMRs on or after first birthday (documentation of specific dates required), OR <input type="checkbox"/> Lab titer showing immunity to Rubeola and Rubella	Enter the two vaccine dates here	Enter the lab titer date & results here	
Chicken Pox (Varicella) <input type="checkbox"/> History of having had the disease, OR <input type="checkbox"/> Lab titer showing immunity, OR <input type="checkbox"/> Documentation of 2 VARIVAX® vaccinations	Enter the two vaccine dates here	Enter the lab titer date & results here	Enter the date you had chicken pox here
Influenza Vaccine – You must provide proof of having received this season's influenza vaccine for job shadows to be scheduled between October 1 – April 15	Enter the vaccine date here and send documentation	Not Applicable	Not Applicable

I verify that the information provided is accurate and hard copy documentation of items listed are on file and available upon request.

Signature & title of person completing this form: _____ **Date:** _____

Anyone who is not immune to Chickenpox, Rubeola or Rubella may not job shadow in a clinical area. Anyone who is symptomatic for TB or any respiratory virus may not job shadow in any area of the hospital.

Information Sheet

Please read the following information prior to submitting your application:

General Information

1. A job shadow is an opportunity to observe an employee. Job shadow participants are not permitted to provide any aspect of patient care.
2. A job shadow experience may be scheduled for 3-6 hours during daytime hours.
3. If you are unable to report for your scheduled job shadow experience, please notify Jennifer DeVries at (616) 252-7009 or Lisa Dewhurst-Walker at (616) 252-5115 for nursing.

Infection Prevention

Proper hand hygiene helps prevent the spread of infections from one person to another. Hand hygiene products, which contain a special antibacterial agent, are available in the rest rooms, work areas and cafeteria. Hands should be rinsed well using friction to remove residual soap.

Hazardous Materials

Potentially hazardous chemicals and materials are used in certain areas as part of the daily operation of a department. Safety Data Sheets (SDS) which describe the hazard and handling instructions for all chemical products are available online and by fax.

Smoking

The entire hospital campus and physician offices are smoke-free.

Dress Code

Please adhere to the following dress code, unless otherwise directed:

- Comfortable closed-toe shoes with socks or hose
- Uniform, or shirt (no slogans) with slacks or skirt
- No fragrance

Health Requirements

You must be in good health and immunizations/boosters must be up-to-date. Completion of the Health Screening Form is required.

Confidentiality

Please read and sign the attached confidentiality agreement.