Job Shadowing Application

Name:_____

Address: _____

_____

Phone Number: _____ Alternate Phone Number: _____

Email Address: _____

Are you a current student? Yes or No?

If yes, where are you currently attending school? _____

What is your student status (freshman, sophomore, junior, senior)? _____

Shadowing is scheduled Monday-Friday. What are your preferred dates and times for shadow experience?

First Preference: _____
Second Preference: _____
Third Preference: _____

What type of position would you like to shadow?_____

In which practice or specialty areas are you interested in shadowing_____

What do you hope to gain from this experience?_____

_____

Emergency Contact Person (name, relationship and phone number):

Name: _____ Relationship: _____

Phone: _____ Alternate Phone: _____

UPMC | PASSAVANT

Job Shadowing Agreement

I understand that job shadowing is an observation experience only, and that no work is to be performed. At the start of my job shadowing, I will be assigned to an employee who will lead me through a department in a hospital. They will discuss a typical workday, explore different aspects of working in a healthcare setting, and identify the skills that are needed in the working world. While on the UPMC premises, I will abide by all policies, rules and regulations of UPMC and follow the direction of the employee to whom I am assigned.

Liability Release

I hereby release and discharge UPMC, its agents, servants, and employees, and persons, firms or corporations contracting with, or acting on behalf, of these groups, with respect to the activities of the Shadow Program as well as their heirs, executors, administrators, successors, or assigns, from any cause of action of any nature whatsoever arising from my participation in the activities of the Shadow Program.

Photo Release

I understand that there is a possibility that job shadow students may be photographed during their experience to help promote the program. I grant permission to be photographed for this purpose.

Authorization for Medical Treatment

I hereby authorize UPMC to provide emergency or urgent medical treatment as deemed advisable by any physician or surgeon on the professional staff of UPMC. UPMC will not be responsible for the costs of such medical treatment. I understand that this authorization is given in advance of any specific diagnosis, treatment or hospital care required, and that UPMC will rely on this authorization only in the event of any emergency or urgent situation. In the case of a minor student, every effort will be made to contact the parent/guardian listed prior to treatment, and the consent will only be used at a time when the parent/guardian consent may not be available.

Customer Service, Inclusion and Respect

UPMC has a mission of ensuring that inclusion is at the core of what we do every day. Inclusion begins with a core belief that everyone deserves dignity and respect. It is the policy of UPMC to promote an environment free from verbal or physical violence and harassment in the workplace or anywhere on the hospital campus, and to provide access to Public Safety and immediate assistance in the event of an incident involving potential harm to patients, visitors and employees.

Culture Awareness – Understanding and respecting patients' cultural values, beliefs and practices are important. A patient's ethnic or religious affiliation may affect how they view health care.

Removal from the Job Shadowing Program

I understand that UPMC may remove me from the job shadowing program for any reason, or no reason at all. This includes, but is not limited to:

- My failure to abide by the terms of this agreement or UPMC policies;
- My failure to act in a responsible and mature manner; or

If UPMC believes it is in my best interest, or the best interests of its patients or staff.

By signing below, I acknowledge that I have read the UPMC Passavant Career Shadowing guide and agree to the terms and conditions. I agree to comply with UPMC policies and procedures as they relate to my shadowing experience. I verify that I am 15 years of age or older.

Signature of Job Shadowing participant: _____

Printed Name:_____Date:_____

Signature of Parent/Guardian (required for high school students): _____

Printed Name:_____ Date:_____

Telephone (work) _____ (cell phone or home) _____

UPMC Passavant Job Shadowing: Intent to Participate Form

(To be completed if participant is 18 years or older)

I, _____, request to participate in all activities associated with the UPMC Job Shadow Program. The purpose of the Shadow Program is to broaden my understanding of a particular career by observing an experienced, competent mentor while he or she performs jobs, duties, and responsibilities within the work environment. In general, the shadow experience will last for three (3) days or less.

I understand that to participate in the Shadow Program, I will need to provide medical health questionnaire, confirmation of receiving flu vaccination and a signed Confidentiality Agreement. I will comply with all rules and regulations of the hospital while in this program. I understand that failure to comply with the hospital's rules will result in immediate removal from the Shadow Program.

I hereby release and discharge UPMC, its agents, servants, employees, and persons, firms, or corporations contracting with, or acting on behalf of these groups, with respect to the activities of the Shadow Program, as well as their heirs, executors, administrators, successors, or assigns, from any cause of action of any nature whatsoever arising from my participation in the activities of the Shadow Program.

_____ _____

Shadow Program Participant (Sign) Date

RELEASE OF LIABILITY FOR HIGH SCHOOL STUDENTS - Please read carefully before signing.

SIGNATURE OF PARENT/GUARDIAN is ***REQUIRED*** if participant is **less than 18 years old.**
This is a legally binding Release made by,_____and_____
(Print full name of parent) (Print full name of parent)
to UPMC Health System, any other controlled or owned subsidiary of UPMC Health System, their directors, officers, employees, agents and contractors. (Collectively, the Released Parties).

I/We recognize and understand that my/our child_____desires to
(Print full name of child)
participate in a Job Shadow Day which will consist of one or more of the following activities: providing an opportunity for a student(s) to "shadow" an employee and participate in workplace activities at our facility; provide an opportunity for a small group of students to tour our facility; and/or speak to a group of students about UPMC employment positions within the organization. I/We understand that UPMC Health System and any other Released Parties do not require my/our child to participate in these activities. However, we are willing to have my/our child participate despite the possible dangers and risks as set forth herein.

I/We fully recognize that there are dangers and risks to which my/our child may be exposed by participating in any or all of these activities, either directly by way of my/our child's own actions or by the actions of others, including but not limited to injuries or conditions such as lacerations, abrasions, contusions and fractures, dental damage, brain injuries, as well as other injuries up to and including loss of life. I/We authorize our child's participation in the activities with full appreciation of the adherent risks and the release of liability provided herein.

I/We agree to assume all of the risks and responsibilities in any way associated with these activities. In consideration of and return for the services provided to me/us by UPMC Health System and the Released Parties, I/we hereby release each and all of the them from any and all liability, claims and actions that may arise from injury or harm to my/our child or from damage to his/her property, in connection with these activities. I/We understand that this release covers liability, claims and actions caused entirely or in part by any acts or failures to act of UPMC Health System or any of the Released Parties, including but not limited to negligence, mistake or failure to supervise by UPMC Health System, or any other Released Parties.

I/We understand that this Release means I/we am/are giving up, among other things, the right to sue UPMC Health System, or any other Released Party for injuries, damages or losses my child or I/we may incur. I/We also understand that this Release binds my/our heirs, executors, administrators and assigns, as well as myself/ourselves. Further, I/we agree to defend, indemnify and hold harmless UPMC Health System, and any other Released Parties from and against any claim, damage, liability, injury expense or loss, including but not limited to reasonable attorney fees, by reason of any suit, claim, demand, judgement or cause of action initiated by or on behalf of _____(Child's name) arising out of or in connection with his/her participation in these activities. I/We further represent that to the best of my/our knowledge, information and belief, my/our child is physically able to participate in the above-described activities, without any undue or unusual risk to him/her or to others.

I/We have read this entire Release. I/We fully understand it and I/we intend to be legally bound by it.

Releasor's Signature	Releasor's Signature	Date

Confidentiality and HIPAA Compliance

PROTECTING PATIENT PRIVACY: EVERYONE'S RESPONSIBILITY

Patients have the right that their information is kept confidential. As such, UPMC considers that all patient information is confidential. Additionally, both federal and state law requires UPMC to keep patient information confidential (including mental health, HIV, and drug and alcohol related treatment information).

Patient information includes such things as:

- The patient's name and other general information about the patient;
- The patient's diagnosis and other medical conditions that the patient may have;
- Treatments, tests and medications that the patient receives; and
- Information in the patient's medical record, contained in UPMC's computer systems or other information that might be posted in the patient's room.

As part of the job shadowing program, I understand that I will be in a facility where patients are being treated. Additionally, as a part of the job shadowing program, I may take tours and/or be provided with demonstrations. I understand that through the course of the job shadowing program, tours or demonstrations, I may come into contact with patient information. I understand that UPMC is obligated under both federal and state law to keep patient information confidential. I further understand that if I encounter patient information through the course of the job shadowing program, tours or demonstrations, it is solely for the purpose of demonstrating concepts of principles, and not for the purpose of disclosing the patient's information, condition, diagnosis or treatment. I agree that I will not attempt to view any patient information. I also agree that I will not copy or otherwise remove any patient information from the facility. Additionally, I agree that I will not disclose to others any patient information that I may come into contact with.

What is HIPAA? The Health Insurance Portability & Accountability Act of 1996 and the regulations which were enacted by the US Department of Health and Human services to implement the Act, provide new rules for how hospitals and other health-care providers, such as UPMC, are permitted to use and disclose or release patient information.

Who is affected? All healthcare organizations and providers, such as UPMC, our medical staff and any member of UPMC's "workforce."

Are there penalties? HIPAA calls for severe civil and criminal penalties for noncompliance, including fines up to $25,000 for multiple violations of the same standard in a calendar year; fines up to $250,000; and/or imprisonment up to 10 years for knowing misuse of identifiable patient information.

Privacy and Confidentiality: In general, privacy refers to a patient's right to access his/her health information. The rule covers all individually identifiable health information that health care organizations and providers, such as UPMC, possess.

The Privacy standards:

- limit the use and release of private health information without patient/parent consent;
- give patients new rights to access their medical records and to know who else has accessed them;
- restrict most disclosure of health information to the minimum needed for the intended purpose;
- establish new criminal and civil sanctions for improper use or disclosure; and
- establish new requirements for access to records by researchers and others.

Implementing HIPAA : It is the policy of UPMC to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule pertaining to the use and disclosure of Protected Health Information (PHI). A number of policies have been developed to assist in our compliance efforts. A student's access to a patient's medical record shall only be with the written authorization of his/her UPMC Sponsor.

Non-Compliance: Your failure to abide by the HIPAA regulations and UPMC policies concerning patient information may result in your immediate dismissal from the Shadow Program, as well as all other penalties described above.

Program Participant (Sign): _____ Date: _____

Drug-Free Workplace

It is the policy of UPMC to provide a drug-free work environment in accordance with the Drug-Free Workplace Act of 1988. The unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance on UPMC premises or while conducting UPMC business off UPMC premises is absolutely prohibited. Violations of this policy will result in corrective actions, up to and including termination.

The Drug-Free Workplace Act requires that I abide by this policy and report any criminal convictions for drug-related activity in the workplace no later than five (5) days after conviction.

UPMC policy requires that I notify my supervisor of any arrest or indictment under any criminal drug statue for a violation in the workplace or outside of the workplace no later than five (5) days after the event. UPMC policy further requires that I notify my supervisor within five (5) days of any criminal conviction other than a summary offense.

UPMC policy requires that I report for duty free from any unauthorized influence of any controlled substance for the duration of my employment.

I have read and understand this policy and will, as a condition of externship, abide by it.

Print Name _____

Externs Signature _____

Date _____

Job Shadow Health Questionnaire

For Signs and Symptoms of Potential Communicable Diseases

Name: _____

Please complete each question below:	Yes	No	Unsure
1. Do you have a persistent cough? (i.e., a cough lasting longer than three weeks?)			
2. Do you have night sweats?			
3. Have you had significant weight loss (10 lbs.) in the last three weeks?			
4. Have you had unexplained fever in the last three weeks?			
5. Do you have a lack of appetite?			
6. Are you coughing up bloody sputum?			
7. Have you had contact with someone that has Tuberculosis?			
8. Have you had a positive tuberculosis skin test in the past?			
9. Do you have diarrhea?			
10. Do you have a skin rash?			
11. Do you have any eye drainage?			
12. Have you had chicken pox?			
13. Have you had measles?			
14. Have you had German measles (rubella)?			
15. Have you had mumps?			

Signed: _____ Date: _____

If under 18, please have parent or guardian fill out the following information:

Name: _____ Relationship: _____

Signed: _____ Date: _____