Shadowing Experience Application

Minimum eligibility requirements:

- 16 years of age
- Able to articulate learning objectives
- Willing to adhere to professional appearance and behavior guidelines
- Free of exposure to infectious disease in the 14 days prior

Name: _____ Birth Date: _____

E-Mail Address: _____

Home Phone: _____ Cell Phone: _____

Address: _____
Street City Zip

School: _____ Grade: _____

Are you requesting to shadow a nurse? ☐ Yes ☐ No

If no, what healthcare position do you wish to shadow? _____

What department(s) interest you? _____

How many hours do you desire? _____ Do you know an associate you wish to shadow with? ☐ Yes ☐ No

If yes, Associate name: _____

What do you hope to gain from being here? ☐ School/Application Pre-Requisite ☐ Career Discernment
☐ Personal Interest ☐ Other *(specify)* _____

☐ *(Initial)* I understand that I must provide proof of immunizations, including Mumps, Measles, Rubella, Hepatitis B, Varicella, Tetanus, and a negative TB skin test, (within the past 2 years). (If you do not have a current TB test, see your physician to complete this requirement. Please attach documentation to this application **PRIOR TO APPLYING FOR THE SHADOW EXPERIENCE.**)

If you are shadowing here between October 1-March 30, you must complete the following:

☐ *(Initial)* I understand that I must provide proof of my current annual influenza vaccination. (If you do not have a current flu vaccine, see your physician or flu shot clinic to complete this requirement. Attach the documentation to this application **PRIOR TO APPLYING FOR THE SHADOW EXPERIENCE.**)

This applies to individuals 18+ years of age only:

☐ *(Initial)* I understand that upon confirmation of the shadow experience, I must provide a current criminal background check, which must include a National Criminal Database Search with nation-wide Registered Sex Offender search and Healthcare Sanctions (OIG/GSA), Office of Inspector General (OIG) Search, at my own expense, with the understanding that I will not receive reimbursement for such cost from Centura Health or any of its facilities. (Please provide the documentation ***UPON RECEIPT OF THE DATE AND TIME OF THE SHADOW EXPERIENCE.***)

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In case of emergency: _____ _____
Contact Name Contact Phone

When I shadow, I will honor the confidentiality of the patients, associates and business of Centura Health and all of its facilities. I will not mention or discuss patients within the facility or away from the facility. I understand that this shadowing experience will not exceed 3 days. I also understand that this experience is to observe only and I will not be touching patients nor providing any care to patients. I further understand that I am not covered by the facility workers' compensation policy. If I am injured during my shadow experience, my personal health insurance will be billed. It is a privilege to observe business and patient care activities at Centura Health and its facilities, and I agree to follow the directions and guidance of the associate I am shadowing. I further understand that in order to participate in a shadow experience, my current criminal background check must be approved.

_____ _____
Signature of Applicant Date

If the applicant is under the age of 18, the parent/legal guardian signature below indicates your approval and support of your child's application to shadow at any Centura Health facility.

In case of injury, permission is granted to Centura Health to give emergency care, if necessary. I understand that my child is not covered by Centura's workers' compensation policy and if injured, my minor child's personal health insurance will be billed.

_____ _____
Parent/Guardian Signature Date

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SHADOWING AGREEMENT WAIVER, RELEASE & CONFIDENTIALITY STATEMENT

In consideration of participating in an educational shadowing experience with Centura Health, I indemnify Centura Health and all its facilities and hold harmless its subsidiaries, representatives, agents and employees from liability, which may result from my participation. I will not bring nor cause to be brought on my behalf any legal action against Centura Health.

Recognizing that my educational shadowing experience provides access to a variety of information deemed strictly confidential, I accept that it is the patient's right to refuse permission for me to observe the delivery of medical care or services delivered to that patient. I acknowledge my obligation to maintain the confidentiality of all information which I may possess as a result of the shadowing experience and that disclosing such information is prohibited and unethical.

I acknowledge the risk that medical and surgical procedures may include graphic and shocking images along with explicit discussion of the human body. I acknowledge and assume the risk that patients, physicians, nurses and others involved with the delivery of medical care may unknowingly expose me to infection and/or illness.

It is my voluntary decision to participate in this educational experience and agree to conduct myself in an appropriate manner, to take direction from appropriate personnel and to dress in a professional manner.

Further, I acknowledge that this shadowing agreement does <u>not</u> authorize me to perform patient care, and that the unauthorized performance of patient care shall result in my automatic removal from the facility.

Shadower Name:_____
(Please Print)

Shadower Signature:_____

Date:_____

Email Address:_____
(Please Print)

Shadowing Experience Application

If the applicant is under the age of 18, the parent/legal guardian signature below indicates your acknowledgment and agreement to the terms of the Waiver, Release and Confidentiality Statement above, on behalf of your child.

In case of injury, permission is granted to Centura Health to give emergency care, if necessary. I understand that my child is not covered by Centura's workers' compensation policy and if injured, my minor child's personal health insurance will be billed.

Parent/Guardian Signature

Date