



Job Shadow Process

Please use the checklist below to complete items that are required for you to complete a job shadow experience.

- _____ Review Job Shadow policy.
- _____ Complete and sign Job Shadow Application form.
- _____ Review and sign Confidentiality Statement of Understanding.
- _____ Complete and sign waiver. Requires signature of a parent or legal guardian if you are under age 18.
- _____ Provide documentation of immunizations. Must also have documentation of a recent TB skin test (completed within the last year). Please use the form included with this packet **and** provide documentation to support the information from your physician or student health center.
- _____ Review orientation packet and sign acknowledgement of completion.
- _____ Notify Human Resources if there are any physical accommodations we need to be aware of.
- _____ Return completed forms to:
 - Trinity Regional Medical Center
 - (Attn: Human Resources)
 - 802 Kenyon Road
 - Fort Dodge, IA 50501

 - Fax number: 515-574-6683
 - Email: UPH_FtDodge@unitypoint.org

Returned forms should include:

- Job Shadow application
- Confidentiality Statement of Understanding
- Job Shadow Agreement and Waiver
- Health/Immunization record with attachments of record from provider or state immunization registry
- Orientation acknowledgement

The above items must be completed prior to being approved for a job shadow experience. We attempt to accommodate requests, however some requests may be denied.

Upon receipt of these items your request will be reviewed and you will be contacted with information regarding date, time, name of assigned staff member and where to report.



Job Shadow Application

Personal Information (please print legibly)

First Name _____ Last Name _____ MI _____

Home Address _____

City _____ State _____ Zip _____

Email _____

Phone Number _____ Cell Phone _____

Are you at least 18 years of age? _____ Yes _____ No If no, date of birth _____

If you are under 18 please list name and contact information for parent/legal guardian.

Name _____ Phone _____

Are you currently a student? _____ Yes _____ No Year in school _____

Name & Address of school _____

What occupation or department do you want to shadow? _____

_____ UnityPoint Clinic _____ Trinity Regional Medical Center _____ Berryhill Center

Name of person you would like to shadow, if known _____

Briefly describe your reason for wanting to job shadow, including your learning and career objectives, number of hours you want to shadow, class/course requirements, etc.

What date(s) and time (s) are you available for your job shadow?

Is this a requirement for a class/course in which you are currently enrolled? ___ Yes ___ No

If yes, instructor's name _____ Phone _____

Applicant Signature _____ Date _____



Job Shadow Agreement and Waiver

As a job shadow participant, I agree to and will comply with the above rules for my job shadow experience with UnityPoint Health – Fort Dodge. I will act professionally and in a manner that is a positive reflection of UnityPoint Health – Fort Dodge. I understand that I am to observe only and am not permitted to participate in any aspect of patient care. Additionally, I understand that UnityPoint Health – Fort Dodge, nor any of its employees or officers may be held liable in any way for any injury, illness or other damages to me arising during this job shadowing experience.

Applicant Signature _____ Date _____

Applicant _____ Name of School _____

Home Address: _____

Phone Number: _____ Year in school: _____

High School Students:

Teacher/Counselor Name _____

High School Counselor/Teacher Signature _____

Date _____

Parental/Guardian Consent for students under the age of 18:

As parent/legal guardian of the above participant, I consent for this individual to participate in a job shadow experience at UnityPoint Health – Fort Dodge and to release UnityPoint Health – Fort Dodge from any claims that may arise from this observation experience.

Parent/Guardian Signature _____ Date _____

Parent Name _____ Phone Number _____



UnityPoint Health
Fort Dodge

Confidentiality Statement of Understanding

I agree to keep patient, clinic and hospital information to myself. I agree that I will not discuss information regarding patients to anyone at the facility or outside the facility unless the communication is necessary to provide care to the patient. Patient and clinic/hospital information is highly confidential and I realize that I could be held liable in a lawsuit for a breach of confidentiality. I understand that there may be patients that I know or recognize, but that I must not disclose that information.

Print Name

Signature

Date

.....
For Human Resources Use

Department _____

Job Shadow Supervisor _____

Job Shadow Date _____

Health/Immunization Record

Provide documentation of completed vaccines and results of testing in addition to completing this section.

Immunizations

Mantoux/TB Test

Date: _____

(Must be within previous 12 months of date of job shadow)

Measles/Mumps/Rubella (MMR)

Date: _____ Date: _____

Tetanus-Diphtheria or Tetanus-Diphtheria-Acellular Pertusis (Tdap)

Date: _____

Chicken pox vaccine

Date: _____

If you have not had Chicken pox vaccine have you had chicken pox? ___ Yes ___ No

Influenza:

Date: _____

Please note: During Influenza season (October-March) documentation of influenza vaccination for the current season will be required. If not vaccinated will be required to wear a mask during observation except for breaks and meal break if masking has been implemented (usually December-March).

Optional:

Hepatitis B Vaccine (series of 3)

Date: _____

Known allergies _____

Current infectious disease, chronic health problems or immune disorders

I understand that I may be exposed to contagious diseases, infectious materials, bloodborne pathogens, and other risks associated with the healthcare environment. I will comply with all Infection Prevention policies, but understand that there is still risk involved.

Applicant Signature _____ Date _____

Student Name: _____

Parental/Guardian Consent for students under the age of 18:

Parent/Guardian Signature _____ Date _____

Parent Name _____ Phone Number _____