



# Job-Shadow Application

*“On-the-job insight to rewarding careers in rural healthcare.” Your application will be kept confidential.*

**Thank you for your interest in job-shadowing at Upland Hills Health!**

Please complete and return this application to our Community Relations Department (address on the last page.) More details, our policy and bloodborne pathogens information can be found by visiting our website, [www.uplandhillshealth.org](http://www.uplandhillshealth.org) and clicking on “Job Shadowing.”

**Please note there are TWO signature lines with this application. Please sign in both places. If you are under age 18, a parent/guardian must also sign in both places.**

**Please print neatly or type:**

Student's Name:		Today's Date	
Mailing Address:			
Daytime Phone Number:		Email Address:	
Date of Birth:		Current Age:	
Current School/ College (if applicable):		Year in School (if applicable):	
Specific Class and/or Instructor (if applicable):			
Career interest, area or unit, if known <sup>1</sup> :			
Name of person you would like to shadow, if known:			
Preferred days to take part in a job shadow experience:	Select all that would work for you. Or list any/all specific calendar dates you prefer:: <input type="checkbox"/> Mon <input type="checkbox"/> Tue <input type="checkbox"/> Wed <input type="checkbox"/> Thur <input type="checkbox"/> Fri <input type="checkbox"/> Sat <input type="checkbox"/> Sun		
Preferred times:	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evenings		
Please list or describe any specific questions or concerns you may have regarding a job-shadow experience:			

<sup>1</sup> Visit [www.uplandhillshealth.org/jobshadowing](http://www.uplandhillshealth.org/jobshadowing) for links to descriptions of various healthcare occupations.

Student's Name: \_\_\_\_\_

**Job Shadow Application Quiz**

To better document our job-shadow students’ understanding of infection control, our privacy requirements and other procedures relating to job shadowing, we have developed the following quiz. Please read the educational materials for job-shadowing students, found on our website at <http://www.uplandhillshealth.org/jobshadow/index.html>. Then complete this short quiz:

1. It is a breach of confidentiality if I go home and tell my family that our neighbor, who is a close friend, is being hospitalized.            True            False
2. It is a breach of confidentiality if I write a report about a patient I observed after my job shadow for a class project.  
True      False
3. It is a breach of confidentiality if I read the diagnosis, treatment, test results, financial, or other information on a patient’s chart.    True            False
4. Hand washing is the most important procedure for controlling infection.    True            False
5. I should wash my hands frequently, especially after using the restroom, sneezing, touching my hair, face, shoes, and before leaving for home.            True            False
6. Bloodborne pathogens are viruses, bacteria or other microorganisms that are carried in the bloodstream that can cause disease.            True            False
7. I should cover cuts, scrapes, hangnails, rashes, etc. while job shadowing and wear personal protective equipment if I feel uncomfortable with my level of protection in a patient care area.  
          True            False
8. While I am at Upland Hills Health, I should wear clothing that is comfortable, yet neat and clean, and I should present a professional appearance.            True            False

**Job Shadow Agreement:**

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

1. I, \_\_\_\_\_, have requested, and Upland Hills Health hereby grants permission to be present in the hospital, nursing home, home health, or hospice setting for observation to enhance my education.

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

- a. Read Upland Hills Health’s job shadow program policy, and adhere to the policy. I will ask questions if I do not understand the policy;
- b. Present this signed and completed application prior to the job shadowing experience (if a minor, a parent or legal guardian's signature is mandatory);
- c. Follow good hand-washing techniques;
- d. Adhere to the job shadow dress code;
- e. Wear personal protective equipment if there is a potential of contacting blood or other body fluids;
- f. Wear a name tag identifying myself as a student;

Student’s Name: \_\_\_\_\_

- g. Inform my mentor/Community Relations staff if at any time I feel nauseous, dizzy or otherwise ill during the shadowing activity;
  - h. Arrive promptly and remain flexible to allow for extenuating circumstances such as patient emergencies that might interrupt the schedule;
  - i. Remain at all times where directed and leave the areas when requested to do so by a physician, nurse, or administration; and
  - j. At the conclusion of my assignment, complete an evaluation of the program and return it to the Community Relations Department.
- 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.
- III. I recognize that observing in the healthcare setting and any complication thereof may be emotionally distressing. I also recognize the primary responsibility of the physicians and personnel is to the patient; therefore, it may not be possible to provide immediate attention to me should the need arise.
- IV. I understand this permission granted may be revoked at any time during the observation period by the attending physician or other staff.
- V. In consideration of the permission granted, I hereby release the physicians, the organization, and its employees from any claims or liability, physical injury and/or damage including emotional distress or injury or mental anguish which may be sustained by me or the patient 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.

**WITNESSED BY:**

**SIGNED BY:**

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian of Minor

\_\_\_\_\_  
Date

**Job Shadow Application Health Screening:**

**PERSONAL HEALTH HISTORY:**

- 1. List any chronic health problems or immune disorders: \_\_\_\_\_  
\_\_\_\_\_
- 2. List any allergies: \_\_\_\_\_
- 3. Describe any chronic skin conditions or open wounds: \_\_\_\_\_  
\_\_\_\_\_
- 4. Have you ever had any exposure with active tuberculosis?     Yes                       No

Student's Name: \_\_\_\_\_



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- 5. Have you ever had a positive TB skin test?  Yes  No
- 6. Have you ever had chicken pox?  Yes  No
- 7. Have you had the chicken pox vaccine?  Yes  No

### IMMUNIZATIONS:

Please list immunizations for the following diseases or attach a copy of immunization records:

Measles, Mumps, Rubella (MMR) \_\_\_\_\_ (You must list two dates.)

Tetanus: \_\_\_\_\_ (Most recent immunization.)

Hepatitis B: \_\_\_\_\_

Other: \_\_\_\_\_

**I certify that the foregoing health history statements are true and complete.**

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Signature of Parent/Guardian:** \_\_\_\_\_

**Date:** \_\_\_\_\_

### OFFICE USE ONLY - DO NOT WRITE BELOW THIS LINE

Health history reviewed by: \_\_\_\_\_

Date: \_\_\_\_\_

Any restrictions?  Yes  No If yes, list restrictions: \_\_\_\_\_

Follow-up action as indicated: \_\_\_\_\_

Mentor: \_\_\_\_\_

Mentor scheduled for date/time: \_\_\_\_\_  Mentor packet sent on date: \_\_\_\_\_

Student confirmation/ notification sent on date: \_\_\_\_\_  Evaluation request sent on date: \_\_\_\_\_

**Thank you for taking the time to complete this application.** We are eager to introduce you to rewarding careers in rural healthcare! We will review your application and do our best to match you with an appropriate mentor. All sections of this application must be completed prior to your job-shadowing experience. Please return this application to:

### Upland Hills Health Community Relations

800 Compassion Way, Dodgeville, WI 53533

FAX: (608) 930-7250 Email: [UHH\\_Community\\_Relations@uplandhillshealth.org](mailto:UHH_Community_Relations@uplandhillshealth.org)

Student's Name: \_\_\_\_\_