Mid-Missouri
Area Health Education Center
1110 West Eleventh Street Rolla, MO 65401
Fax: 573.364.8972

Job Shadowing Application

_____ _____ _____
Last Name First Name Middle Initial

_____
Current Address: Street, City, State, Zip Home Phone

_____ _____
Cell Phone **E-mail Address**

_____ _____ XXX-XX- _____
Current Age Date of Birth Last four digits of Social Security Number

_____
Current School

_____
School and Program Applying to:

1._____ 2. _____ 3. _____
Department(s) you wish to shadow in order of preference

Your Availability to Shadow

Complete applications will be processed in the order they are received. It may take up to two weeks for your application to be processed.

Please list your first, second, and third-choice dates and times based on your job, school schedule, etc. Also state what time/day is best for you if your first three specific dates are not available. For example, if you want to shadow on Monday the 10th of the month, but you are available any Monday, any shift, please write "any Monday, any shift" in the right-hand column.

1st choice date: _____ or Day of Week/Time_____

2nd choice date: _____ or Day of Week/Time_____

3rd choice date: _____ or Day of Week/Time_____

You will be notified of the date, time, and place you are scheduled to shadow through the e-mail address you have written above. Please make sure it is legible.

Only complete applications will be processed.

Participant Name: _____ Participant Birth Date: _____

Emergency Contacts

In case of medical emergency, Mid-MO AHEC must be able to reach a relative or other emergency contact.

Primary Contact:

Name:_____

Relationship: _____

Address: _____

Primary Phone: _____

Other Phone: _____

Secondary Contact:

Name: _____

Relationship: _____

Address to student: _____

Primary Phone: _____

Other Phone: _____

Release of Liability

I hereby agree that while I am participating in any Mid-MO AHEC educational experience, the Mid-Missouri AHEC, the Missouri AHEC system, and the healthcare facility will not be held responsible for any injury or accident that might occur. Any medical expenses incurred as a result of such injury or accident will be my responsibility.

_____ _____

Participant Signature
(Parent/Guardian Signature if participant is under age 18)

Date

Medical Release

(For participants under age 18)

I understand that in case of a medical emergency, every attempt will be made to contact me before medical action is taken. However, this document is my consent as a parent or guardian of the participant for emergency treatment or procedure necessary by the professional staff of the closest hospital available.

_____ _____

Parent/Guardian Signature

Date

_____ _____

Insurance Company

Policy Number

Participant Name: _____

HIPAA Training Post Test

1. You can tell other people you saw a patient at the hospital, as long as you don't look at their records.
    a. True
    b. False

2. Individuals can be held personally liable for privacy violations.
    a. True
    b. False

3. The privacy rule protects:
    a. Patient information transmitted electronically (faxes, e-mails, etc.).
    b. Patient information in paper form.
    c. Patient information communicated orally.
    d. All of the above.

4. It is acceptable to look at other patients' records even if it does not pertain to your job, as long as you do not pass this information along to anyone else.
    a. True
    b. False

5. In talking about patients, you should ask yourself:
    a. Is this confidential information?
    b. Is the person I am talking to part of the patient's healthcare team?
    c. Am I in a private place so others won't hear?
    d. Is sharing this information for the patient's benefit? Is it gossip?
    e. All of the above.

6. Betty's new patient, Mr. Jones, goes to Betty's church. Betty told her pastor that Mr. Jones was in the hospital and going to have surgery. This is okay because Mr. Jones would probably enjoy a visit from the church members.
    a. True
    b. False

7. You may look up patient information in the electronic health record for the following reason(s):
    a. If your co-worker needs information and doesn't have the appropriate access.
    b. To treat your patient.
    c. To access your minor child's record.
    d. To see who is in the Emergency Department.
    e. All of the above

8. It's part of your duty to keep your patient's medical information private.
    a. True
    b. False

9. You should log out of the electronic health record:
    a. If you are going on a break or to lunch.
    b. If someone else wants to use the computer.
    c. If you are walking away from the computer for a few minutes.
    d. All of the above.

10. If people work in the same place you do, it's okay to discuss a patient with them.
    a. True
    b. False

HIPAA PRIVACY ATTESTATION FORM

The purpose of this agreement is to help you understand your obligations regarding confidential information that you may have access to. Confidential information includes information about specific patients you may see at the hospital, and/or their medical information.

Confidential information is protected by Federal and State laws, regulations, including HIPAA, and the Joint Commission on Accreditation of Healthcare Organizations standards.

As a visitor, you are required to conduct yourself in strict conformance with applicable laws, standards, and regulations.

In the event that you do have access to confidential information, you hereby agree:

- You will not in any way discuss, copy, release, sell, loan, review, alter or destroy any confidential information/data.
- You will not misuse confidential information/data or be careless with it.
- You understand that your obligations under this Agreement will continue after your visit to Phelps County Regional Medical Center ends.

_____
Printed Name

_____
Signature

_____
Date

_____
Parent Signature required if participant is **under** age 18

Tuberculosis or PPD Skin Test

This test can be administered at your County Health Department for a fee.
Missouri S&T students should contact campus Student Health.

Consent for PPD Tuberculosis Skin Test

Participant Name: _____

I UNDERSTAND job-shadowing participants must receive a PPD skin test for Tuberculosis as part of pre-job shadowing requirements. I also UNDERSTAND IT IS MY RESPONSIBILITY to have the test read 48-72 hours after the test is given, by a validated TB test reader. This form **MUST** be returned to the AHEC office as part of the completed Job Shadowing packet.

My signature indicates my agreement to have the PPD test and follow up, and further indicates that I HAVE NEVER HAD A POSITIVE PPD TEST IN THE PAST.

_____
Signature

****

This section to be completed by Health Care Provider

_____
Date of Test

_____ 5 TU/0.1 ml _____
Pharmaceutical Company Lot #

_____ _____
Exp. Date Injection Site

Given by_____

****

Test results_____ Read by _____Date_____
Neg Pos

****

This information may be shared with another Facility or Healthcare provider upon request.
Please initial one: Yes_____ No_____

Important Details

When you are in a shadowing experience, remember you are a representative of the facility, and there are expectations of professionalism. Arrive on time; dress and act professionally. Job shadowing is a privilege, not a right.

- DO NOT CANCEL your job shadowing experience. If you must, call the department contact to explain. RESCHEDULING IS NOT GUARANTEED.

- Wear clean, professional clothing: collared shirts, dress slacks (khakis are fine).
- Wear comfortable shoes, not high heels, not open-toed shoes/sandals.
- NO blue jeans, shorts, short skirts
- NO spaghetti straps or tank-tops
- NO visible body piercings, tattoos or jewelry
- Long hair must be pulled back

- Arrive ten minutes early, introduce yourself, and SMILE
- Use polite language and make eye contact
- Be respectful and engaged; show your interest
- Ask questions (when appropriate); you are here to explore the career
- Remember everything you see and hear is confidential. Keep information to yourself.

- NO smoking, tobacco chewing or gum chewing
- **Turn your cell phone OFF!**
- NO other electronic devices are allowed

- Park in employee parking areas, not the visitor parking spots

I have read the statements above, and I understand that non-compliance with ANY of them can result in the immediate termination of the shadowing experience.

_____ _____

Participant Signature Date