Job Shadow Program Agreement

As a participant in the Shadowing Program, I acknowledge and understand:

1. I will not touch the patients.
    a. If I am allowed to observe a patient having a procedure, I understand that the Memorial employee I am shadowing must introduce me to the patient and obtain the patient's consent for me to observe his/her procedure. If the patient is a minor we must obtain consent of the parent or guardian.
    b. During an emergency code involving a patient, I should not become involved or observe during that time. If the person I am shadowing becomes involved in the emergency, I will remove myself from the immediate area and re-join the employee after the emergency.
    c. During an emergency code not involving a patient (Example: Code Red/fire drill) I will follow the instructions of the person I am shadowing.
2. I will not touch medical equipment.
3. I will not assist in feeding a patient.
4. I will not approach physicians about personal illness or medications.
5. I will dress professionally as outlined in the Job Shadow Guidelines.
6. I understand that I will be required to sign a HIPAA/Statement of Confidentiality wherein I agree to keep all patient information confidential.
    a. I will not access the electronic medical record, written chart, or any hospital computer.
    b. I will not use personal cell phones or pursue personal texting activities in the presence of patients or other customers.
    c. I will not use a camera phone in clinical areas.
    d. I will not post any protected health information or other confidential and/or proprietary information on my Facebook page or any other social network site.
7. I understand Memorial is not held responsible for any accident or injury that may occur on its premises while shadowing.
8. I am to leave valuables at home and realize it is my responsibility that other personal items are secured prior to shadowing.
9. I will not perform my own personal care in the clinical setting (i.e., applying lip gloss, handling contact lenses, eating or drinking, brushing hair, etc.).
10. I will not be permitted in areas of contamination such as isolation rooms or soiled linen areas.
11. I cannot participate in the program on days that I am ill as determined by Memorial.
12. If shadowing 8 hours or less, I will obtain an ID badge through the Professional Development Department and return it each day. If shadowing more than 8 hours, I will obtain my ID badge through Professional Development and return it to the Professional Development Department upon completion of my shadowing.

13. I understand that Memorial shall have the right to immediately terminate my participation in the program if it is determined at the supervisor's discretion that I am not acting in the best interest of the patient or facility. In addition, the supervisor holds the right to terminate shadowing at any point.

HIPAA/Statement of Confidentiality

I am aware that I am not to have direct care contact with patients, their charts, computer systems, or medical equipment. I acknowledge that I have had a review of information regarding HIPAA (Health Insurance Portability & Accountability Act). I understand that ALL information written, verbal, or electronic, from the patient's chart or learned through conference with physicians, patients, family members, or other authorized representatives of the patient is to be handled in a highly confidential manner and is not to be discussed with anyone except on a need-to-know basis. Recording of voice mail or other message systems, telephone or in-person communication, meetings, and the like is not allowed without proper authorization.
I understand that any violation of the confidentiality of patient, medical or business information or misuse of electronic communication equipment or systems may result in termination of my shadow experience and will disqualify me from future student experiences at Memorial.

Acknowledgement Statement

I acknowledge that I have read and understand the information within this document and have been given an opportunity to ask questions. By signing below I acknowledge that I fully understand my role and responsibilities while shadowing at Memorial. I agree to abide by HIPAA guidelines, Infection Control guidelines, and Guidelines for Professional Appearance during my shadowing hours at Memorial. I understand that if I do not abide by the Guidelines set forth I may be asked to leave.

Signature _____

Printed Name _____

Date_____