Grand Island
REGIONAL MEDICAL CENTER

Job Shadowing Form

Date	
First Name	
Last Name	
Address	
City	
State	
Zip Code	
Date of Birth ***Must be 16 and older to apply for job shadowing***	
Email Address	
Cell Phone Number	
Date of Shadowing Experience	
End date of Shadowing Experience	
First name of Provider	
Last name of Provider	
Additional Dates	☐ Yes ☐ No
School attending	
Grade Level	
Program Major	

Departments of Interest (list 1st, 2nd, and 3rd choice):

_____ Environmental Services

_____ Health Information

_____ Lab/Pathology

Nursing (select area of interest):

_____ Cardiology

_____ Emergency Department

_____ Intensive Care Unit

_____ Labor & Delivery

_____ Med-Surg

_____ Neonatal Intensive Care Unit

_____ Oncology

_____ Pediatrics (when available)

_____ Progressive Care

_____ Skilled Care

_____ Nutritional Services

_____ OR/Surgical Services (per policy must be 19 to observe in this area)

_____ Pastoral Services

_____ Physical/Occupational Therapy

_____ Pharmacy

_____ Radiology

_____ Respiratory

_____ Social Work

_____ Other Preference: _____

Your Goal (Please share what you hope to gain from this experience):

HIPAA Confidentiality Agreement:

I have read the above information and I understand what it means to me as a Job Shadower. I understand the importance of maintaining the privacy of all confidential medical information I may encounter during the course of my job shadowing experience and agree to maintain patient confidentiality. I recognize that I may be exposed to potential risks as a result of this activity and will not hold GIRMC liable for any risks as a result of this activity.

Printed Student Name	
Student Signature	

Parental/Guardian Participation Consent:

If student is younger than 19, a parent or guardian's signature is required:

(Student Name)_____ has my permission to participate in the job shadowing experience offered by GIRMC. I have reviewed the terms of this confidentiality agreement with my child, stressing the importance of maintaining the privacy of all confidential medical information he/she may encounter during the course of his/her job shadowing experience. I recognize that job shadowing offers a significant benefit to my child in terms of first-hand exposure to potential career opportunities in the medical field. In consideration for this benefit, I agree to hold harmless and indemnify GIRMC from any liability arising from my child's failure to abide by GIRMC policies concerning the privacy of confidential medical information.

	Date(s) of Immunization:
· DPT/Tdap (Diphtheria, Pertussis, Tetanus	
· Influenza (Flu Shot - October through March)	
· Hepatitis B	
· Inactivated Poliovirus (Polio Vaccine)	
· MMR (Measles, Mumps, Rubella)	
· COVID	
· Varicella (Chicken Pox)	

Print Parent/Guardian Name	
Signature of Parent/Guardian	
Date	

Participant Agreement:

As a participant in the GIRMC Job Shadowing program:

1. I will not touch the patients. If I am allowed to observe a patient having a procedure, I understand the director or manager is to obtain the patient's consent first.
2. I will not touch medical equipment.
3. I understand that I do not have medical record or chart access and will not have computer access.
4. I will not assist in feeding but may help deliver food.
5. I will not approach physicians about personal illness or medications.
6. I will dress professionally as outlined in the Dress and Grooming Standards.
7. I am subject to GIRMCs' drug testing policy. If I object, I will be asked to leave the premises immediately.
8. I understand GIRMC is not held responsible for any accident or injury that may occur on its premises while shadowing.
9. I understand that I am to leave all valuables at home.
10. I understand that any use of a cellular device is prohibited.
11. I will not preform my own personal care in the clinical setting(i.e. applying lip gloss, handling contact lenses, eating or drinking, brushing hair, etc.)
12. I will not be permitted in areas of contamination such as isolation rooms, soiled linen areas, neonatal intensive care, burn unit, behavioral and autopsy room.
13. I understand that I cannot participate in the program on days that I am ill. These include but are not limited to: fever, diarrhea, productive cough, rash, open wound, or COVID symptoms (Fever or chills, cough, shortness of breath, fatigue, muscle or body aches, headache, loss of smell or taste, sore throat, congestion, runny nose, nausea, vomiting, diarrhea, trouble breathing, persistent pain or pressure in the chest, new confusion).
14. I understand that I am required to sign a HIPAA Privacy, Security and Confidentiality Agreement wherein I agree to keep all patient information confidential. Failure to comply may result in dismissal.
15. I understand that GIRMC will have the right to immediately terminate my participation in the Job Shadowing program it is determined at the manager or supervisor's discretion that I am not acting in the best interest of the patient or facility. In addition, the director or manager holds the right to terminate shadowing at any point if deemed necessary.

Job Shadowing Participant Agreement:

Printed Student Name
Signature of Student
Signature of Parent/Guardian Date

Consent for Emergency Treatment

In the case of an injury while participating in career exploration activities at GIRMC, I give my consent for GIRMC, its physicians, employees, and agents to render emergency and other necessary medical treatment. I, _____ (Print Parent/Guardian Name), release GIRMC, its physicians, employees and agents from any costs associated with rending of treatment to the minor that is necessary in an emergency.

Parent/Guardian Signature: Date:

Student Signature: Date:

Emergency Contact Information

Print the name and contact information of an individual who should be contacted in the event of an emergency.

Name: _____

Relationship to applicant: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email Address: _____

Please submit completed forms to girmc_education@giregional.org upon completion.