

## Extended (More than 8 hours) FVHCA Job Shadow Application

**We only offer extended job shadows for the following students:**

1. College/university students who need this observational experience to apply for a specific field of study (School or Radiology/Oncology, Physical Therapy school, etc.)
2. Students currently enrolled in a specific healthcare program (School or Radiology/Oncology, Physical Therapy school, etc.) who need to complete this observational experience to meet program requirements.
  - If you do not meet one of the two requirements above, please work with your college/university contact to consider a student clinical placement if appropriate.
  - Note: due to the high volume of requests for such experiences, each facility will determine if they are able to accommodate your request and if so, how many hours they can offer based on available resources.

**\*\*Please indicate your field of study** \_\_\_\_\_  
 \*\*\*\*\*

**Applicant Name: (Print)** \_\_\_\_\_

**Address:** \_\_\_\_\_  
Street City State Zip

**Applicant Phone:** \_\_\_\_\_ **Email Address** \_\_\_\_\_

**School Representative:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
Counselor, Advisor or Teacher Counselor, Advisor or Teacher

**Emergency Contact & Phone Number:** \_\_\_\_\_

**Total number of Job Shadow (JS) hours needed** \_\_\_\_\_ **Date JS needs to be completed by** \_\_\_\_\_

**Circle the healthcare organization where you wish to complete an extended job shadow (choose only one):**  
 Affinity Health System    Agnesian HealthCare    Aurora Healthcare    Orthopedic and Sports Institute    ThedaCare

**Clinical Role Choice:**    Dietician                      Pharmacist                      PT/OT/Speech  
    Radiology/Oncology    Medical (specific role: \_\_\_\_\_)    Other: \_\_\_\_\_

**Preferred Location (circle one):** Hospital    Clinic    **Preferred Site, if possible:** \_\_\_\_\_

**Preferred Job Shadow Start Date:** \_\_\_\_\_ **Job Shadow Needs to be completed by:** \_\_\_\_\_

Time & Date	Monday	Tuesday	Wednesday	Thursday	Friday
8AM- Noon					
Noon- 5PM					

**Name two goals you wish to achieve through this experience:**

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_

**I understand and agree to the following (initial by each statement):**

- I am visiting for an observational shadowing experience. I am not allowed to, and will not, provide any direct hands-on care \_\_\_\_\_
- I waive liability to the Healthcare organization/FVHCA for any injury or illness that may occur during or as a result of my job shadow experience \_\_\_\_\_
- I am responsible to be on time, present a photo ID, and wear a visitor badge \_\_\_\_\_
- It is my responsibility to notify my healthcare facility contact if I need to cancel/reschedule \_\_\_\_\_
- If I come into contact with anyone who has been diagnosed with measles or chickenpox within three weeks of my experience, I will reschedule with my healthcare facility contact \_\_\_\_\_
- If I am not in good health/feeling ill, I will reschedule with my healthcare facility contact \_\_\_\_\_
- I will abide by the instructions given to me by my mentor during this experience \_\_\_\_\_
- I understand I need to provide copies of immunization records and/or lab results for MMR, Varicella, Hep B and 2-Step TB skin test or IGRA (quantiferon gold test **OR** T-spot) in order for my application to be complete \_\_\_\_\_
- I understand I am responsible for transportation and meals during this experience \_\_\_\_\_

**I have read the Job Shadow Information Sheet; initial that you will adhere to each statement below:**

- I have read and will adhere to the confidentiality agreement \_\_\_\_\_
- I have read and will adhere to the infection prevention information \_\_\_\_\_
- I have read and will adhere to the hazardous materials information \_\_\_\_\_
- I have read and will adhere to the general safety information \_\_\_\_\_
- I have read and will adhere to the tobacco information \_\_\_\_\_
- I have read and will adhere to the dress code information \_\_\_\_\_

In addition, I assume responsibility of all medical costs which result and release Fox Valley Health Care Alliance and its members of all liability. Patient/resident permission is required for all job shadow interactions. I understand that this permission may be withdrawn by the patient/resident at any time. I give the facility at which job shadow is being conducted permission to release my telephone number or contact directions, to the requested department. While I am job shadowing at any site under the Fox Valley Health Care Alliance, I realize that all healthcare information, patient/resident care and records are a confidential matter. All information exchanged while I am observing must be held in strictest confidence.

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**Student Signature**

**Date**

I have reviewed this application with the student and recommend him/her for this observational job shadowing experience.

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**School Representative**

**Date**

## FVHCA Job Shadowing HEALTH REQUIREMENTS FORM

- Copies of Immunization records and/or lab results are needed to verify the information listed below: please be sure to include them when turning in the form.
- The following immunization information is mandatory and must be completed in full.

<b>Student Name:</b> _____	
<b>School:</b> _____	
<b>MMR Measles/Mumps/Rubella Vaccine:</b> MMR – 1 dose must be given after 1980 2MMR's are required OR dates and results of Titers Date of Vaccines #1 _____ #2 _____ OR Rubella Titer Date: _____ <input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune Rubella Titer Date: _____ <input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune Rubella Titer Date: _____ <input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune	<b>Chicken Pox (Varicella):</b> <b>History of Disease ___ Chicken Pox (Varicella):</b> Date of Titer _____ <input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune Or Date (s) of Vaccine #1 _____ #2 _____
<b>Hepatitis B Vaccine:</b> ___ Yes ___ No Date: _____ Date: _____ Date: _____ Complete Signed Declination form: _____	<b>2-Step TB skin test or IGRA (quantiferon gold test OR T-spot) (required annually)</b> Test 1 TB Test Date: _____ TB Test Date Read: _____ Result: _____ mm Test 2 TB Test Date: _____ TB Test Date Read: _____ Result: _____ mm If positive, date of last chest x-ray and symptoms review _____
<b>Flu Shot: (October 1<sup>st</sup>-May 1<sup>st</sup>)</b> Date of Vaccine Administration: _____ Clinical Site: _____	

*Health requirement & policies apply to all students in patient care areas. It is the student's responsibility to submit accurate and timely information. To the best of my knowledge, the above information is correct, and I do not currently have a communicable disease or health condition that would put the patients/clients or myself at risk.*

\_\_\_\_\_  
Student signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Educational Representative

\_\_\_\_\_  
Date



## STUDENT / INSTRUCTOR HEPATITIS B VACCINE DOCUMENTATION

I \_\_\_\_\_ understand that as a student/instructor in a health profession educational program, and due to my educational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection, a **serious disease**.

### Please initial one statement that best explains your situation:

Statement 1:

\_\_\_\_\_ I have **begun** the vaccination series (three doses given over six months). I understand that because I have not completed the series and have not gotten the antibody screen, I continue to be at risk for acquiring HBV, a serious disease. Submit documented immunization record to your school. Enter dates of completed vaccinations thus far:

Date of vaccine #1 \_\_\_\_\_  
Date of vaccine #2 \_\_\_\_\_  
Date of vaccine #3 \_\_\_\_\_

Statement 2:

\_\_\_\_\_ I **have not** completed the Hepatitis B series of three (3) vaccinations:

\_\_\_\_\_ (Initial here) I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk for acquiring HBV infection. I have been given the opportunity to be vaccinated with the Hepatitis B vaccine; however I decline Hepatitis B vaccination at this time.

\_\_\_\_\_ (Initial here) By declining this vaccine, I understand that I continue to be at risk of acquiring Hepatitis B virus (HBV) infection, a **serious disease**. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I will need to discuss this with my healthcare provider. If I am then vaccinated, I will need to supply that documentation to the school.

Statement 3:

\_\_\_\_\_ I **have been** vaccinated for Hepatitis B; please initial one of the following:

Initial one of the following if you have already received the Hepatitis B series of three (3) vaccinations:

\_\_\_\_\_ I have been screened for post vaccine antibodies and the results were positive / reactive.  
**Evidence of results must be attached.**

\_\_\_\_\_ I have been screened for post vaccine antibodies and the results were negative/non-reactive. If the screen shows a negative result, I will consult with my provider for next steps.  
**Evidence of results must be attached.**

\_\_\_\_\_ Although it has been recommended to have post-vaccine antibodies checked, I have chosen not to have this lab test done and I accept the risk of not knowing my immunity status in event of an exposure to blood and/or body fluids.

Date of vaccine #1 \_\_\_\_\_  
Date of vaccine #2 \_\_\_\_\_  
Date of vaccine #3 \_\_\_\_\_

By my signature below I acknowledge that I have been made aware of the measures to prevent HBV infection, and I will not hold my educational institution or any clinical agency accountable for acquired HBV infection.

Printed Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Student ID# \_\_\_\_\_

