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_____

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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):
Ascension Health System SSM HealthCare Advocate/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
5AM-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 anydirect hands-on care ____
- I waive liability to the Healthcare organization/FVHCA for any injury or illness that may occur during or because 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 threeweeks 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 _____
- Iwill 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, COVID, and 2-Step TB skin test or IGRA (quantiferon gold test **OR** T-spot) 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 understandthat this permission may be withdrawn by the patient/resident at any time. I give the facility at which job shadow isbeing 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 amobserving must be held in strictest confidence.

Student Signature **Date**

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

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.**

Student Name:

School:

MMR Measles/Mumps/Rubella Vaccine:

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: ☐ Immune ☐ Non-Immune

Rubella Titer Date: ☐ Immune ☐ Non-Immune

Rubella Titer Date: ☐ Immune ☐ Non-Immune

Chicken Pox (Varicella):

History of Disease___Chicken Pox (Varicella):

Date of Titer_____ ☐ Immune ☐ Non-Immune

Or
Date (s) of Vaccine #1 #2

Hepatitis B Vaccine:

☐Yes ☐No

Date:_____

Date:_____

Date: _____

Complete Signed Declination form:

2-Step TB skin test or IGRA (quantiferon gold test ORT-spot) (required annually)

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

Flu Shot: (October 1st-May 1st)
Date of Vaccine Administration:

Clinical Site: _____

Covid-19 Vaccine: Vaccine name:

Date: _____ **Date: _____**

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

_____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#