4 Hour or Less FVHCA Job Shadow Application

Applicant Name: (Print) _____

Address: _____
Street City State Zip

Applicant Phone: _____ **Email Address** _____

Are you a Student? Yes No High School College/University Grad school

School: _____ **Grade:** _____ **Age:** _____

School Representative: _____ **Phone:** _____
Counselor, Advisor or Teacher Counselor, Advisor or Teacher

If you are not a student, what is your occupation? _____

Emergency Contact & Phone Number: _____

Total number of Job Shadow (JS) hour's needed _____ **Date JS needs to be completed by** _____
(1, 2, 3 or 4)

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

View the list of job roles that are available for the organization you selected above, enter your first and second choices.

First Job Role Choice: _____
Preferred Location (circle one): Hospital Clinic

Second Job Role Choice: _____
Preferred Location (circle one): Hospital Clinic

Please make an X on the dates and times you are available to complete a Job Shadow (NOTE: Placement may take up to 2-3 weeks)

Time & Date	Monday	Tuesday	Wednesday	Thursday	Friday
8AM- Noon					
1PM- 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 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 ____
- I am visiting for a shadowing experience. I am not allowed to provide any direct hands-on care ____
- 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, COVID-19 and Mantoux TB Skin Test 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.

_____

Student Signature **Date**

I have read and understand the information on the Information Sheet and authorize my son/daughter to participate in this job shadowing experience. Fox Valley Health Care Alliance nor its members shall be held responsible for adverse occurrences and/or outcomes. Should my child need medical attention during or as a result of this job shadowing experience, I authorize such medical care and assume full responsibility for any treatments deemed necessary. I assume responsibility for all medical costs which result and release Fox Valley Health Care Alliance and its members of all liability. I give Fox Valley Health Care Alliance and its members permission to release my son/daughter telephone number or contact directions, to the requested department.

_____

Parent/Adult Signature **(*If student is under the age of 18)** **Date**

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

_____

School Representative **Date**

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
2 MMR'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

Mumps Titer Date: ___ ☐☐Immune ☐☐non-Immune

Chicken Pox (Varicella):

History of Disease ___Yes ___No

Date of "Documented" Disease _____

or

Dates(s) of Vaccine #1 _____ #2 _____

or

Date of Titer _____ ☐☐Immune ☐☐non-Immune

Hepatitis B Vaccine:

___ Yes ____ No

Date: _____

Date: _____

Date: _____

Mantoux TB Skin Test (required annually):

Step 1 TB Test Date:
_____
Step 1 TB Test Date Read
_____
Step 1 Result _____ mm

If Positive, date of last chest x-ray and symptoms review
_____

COVID- 19 Need one dose of bivalent vaccine.
Dose 1: _____

Flu Shot: (October 1st – May 1st)

Date of vaccine administration: _____ Clinic 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 myself or the patients/clients at risk.

_____ _____
Student signature Date

_____ _____
Parent signature (if student is under age 18) Date

_____ _____
Educational representative Date

2023-05-01