**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):

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Second Job Role Choice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Location (circle one):Hospital ClinicPreferred 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 flu vaccine 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: \_\_\_\_\_\_\_\_\_\_\_\_\_ | **COVID- 19**  Dose 1 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Dose 2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **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