UR MEDICINE | THOMPSON HEALTH

Shadow/Observer Information

**Must be less than 40 hours with exceptions made by department & associate services. - The shadow will observe the activities of a department. In non-patient care areas, the student may do minor tasks, but the experience is mainly observational. In patient care areas, the shadow is not to render any service which might put him/her in contact with blood or body fluid.*

Name: _____
(Last) (First) (Middle Initial)

Address: _____
(Street) (City/State) (Zip)

Phone #: _____ Cell Phone #: _____

Email Address:_____

School Affiliation: _____

Beginning Date: _____ Ending Date: _____ Number of Hours*: _____
*Can be estimated if unsure of exact number of hours.

Have you contacted the department already? If so, provide name of contact:
_____

Desired department(s): _____

Emergency Contact Information:
Person to Notify in Case of Emergency: _____

Relationship: _____ Phone #: _____

Do you have any impairment that may be of potential risk to the patients, residents, or associates at Thompson Health or that may interfere with your performance of job duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol, or any substance that may alter your behavior?
❑Yes ❑No A yes response will not necessarily lead to any action, although the matter may have to be explored further on a confidential basis. If yes, explain: _____

_____

_____ _____
Signature of Student Signature of Parent/Guardian *(if student is under 18)*

FOR OFFICE USE:

___ Student/Observer Information Form
___ Confidentiality Statement (signed)
___ Health Attestation (signed)
___ Influenza Vaccination Proof (only required through flu season 10/1-5/1)

CONFIDENTIALITY STATEMENT

As a student intern/shadow/observer at Thompson Health, I understand that I will be working with or have access to patient/resident and/or associate information which is confidential. Federal and State statutes and regulations protect the private and confidential nature of patient/resident and/or associate information records.

Moreover, due to the ethical standard of a patient's, resident's and associate's right of privacy, I understand that information I may be exposed to during the course of my work may not be discussed outside the facility or with others within the facility who do not need to know the information for any business or patient/resident care reason.

I understand that anyone with access to patient or other sensitive information through Email, voicemail or our computer system must be keenly aware that this information is highly confidential. Accessing this information will only be done when it is absolutely necessary in order to provide patient/resident care, complete the patient's/resident's medical records or performs the duties necessary to complete my work assignments. Accessing this data must be done with discretion and users must be aware that a record may be maintained for all data accessed. Confidential data should not be copied or transmitted without appropriate approval.

Further, I understand that lack of discretion or unauthorized disclosure of confidential information concerning patients, residents, physicians, volunteers, visitors, fellow associates or Health System business is considered a major infraction of health system policy and may lead to disciplinary action, up to and including termination.

_____	_____
Signature	Signature of Parent/Guardian *(if under 18)*
_____	_____
Print Name	Parent/Guardian Print Name
_____	_____
Date	Date

cc: File

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SHADOW HEALTH ATTESTATION

As a shadow/observer at Thompson Health, I understand that I must not be experiencing symptoms of illness within 24 hours prior to shadow date. These include but are not limited to: Chest discomfort, chills, cough, decrease in appetite, diarrhea, fatigue (tiredness), fever or feeling feverish, headache, muscle or body aches, new loss of taste or smell, runny or stuffy nose, sneezing, sore throat, vomiting, weakness, wheezing or new rash of unknown origin.

I understand that as a shadow/observer that I will not engage in any direct patient contact, and will solely observe and adhere to any applicable infection control policies and procedures to the department in which I am located. I will adhere to masking during flu season per Thompson Health policy if I do not present proof of an updated flu vaccine for the season in which I am shadowing.

_____	_____
Signature	Signature of Parent/Guardian *(if under 18)*
_____	_____
Print Name	Parent/Guardian Print Name
_____	_____
Date	Date