4 Hour or Less FVHCA Job Shadow Application

Applicant Name: (Print) _____

Address: _____
Street City State Zip

Applicant Phone: _____ Email Address_____

Are you a Student? (Circle Choice) Yes No High School College/University Grad school

School: _____ Grade: _____ Age: _____

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

If High School Student, please attach a copy of your certificate of participation to show which Career Experience Event you attended.

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

Emergency Contact or Parent Name & Phone Number: _____

Total number of Job Shadow (JS) hours 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)**:**
Ascension/Affinity Health System Agnesian Healthcare Aurora Healthcare Orthopedic and Sports Institute ThedaCare

View the list of job shadows that are available for the organization you selected above, enter your first and second job role choices that you wish to shadow.

First Choice: _____
Preferred Site: (circle one): Hospital Clinic

Second 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					
Noon- 5PM					

Name TWO goals you wish to achieve through this experience:

1)_____

2)_____

I understand and agree to the following (please 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 will not provide or be required 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 and 2-Step TB skin test or IGRA (Quantiferon gold test **OR** T-spot) in order for my application to be complete. _____
- I will provide proof that I have fully completed COVID-19 vaccination as required. _____
- If I come into contact with anyone who has been diagnosed with COVID-19, measles or chickenpox within three weeks of my experience, I will reschedule with my healthcare facility contact. _____
- 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)** **Phone** **Date**

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

_____

School Representative **Date**

2021-10-5 pb

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.**

<table>
<tr><td colspan="2">Student Name:</td></tr>
<tr><td colspan="2">School:</td></tr>
<tr><td>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</td><td>2-Step TB skin test or IGRA (quantiferon gold test OR T-spot)
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
_____</td></tr>
<tr><td>Hepatitis B Vaccine:

_____Yes _____No

Date: _____

Date: _____

Date: _____</td><td>Chicken Pox (Varicella):

History of Disease ____Chicken Pox (Varicella):

Date of Titer _____ ☐ Immune ☐ Non-Immune

Or
Date (s) of Vaccine #1_____ #2_____</td></tr>
<tr><td>COVID-19 Vaccination: Type (circle one):

Johnson & Johnson Moderna Pfizer

Date of Dose 1: _____

Dose 2: _____

Booster: _____</td><td>Flu Shot: (November 15th-May 1st)

Date of Vaccine Administration: _____

Clinical Site: _____</td></tr>
</table>

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 18) Date

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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# _____

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