

# Student Job Shadow Application

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## Personal Information

Name: \_\_\_\_\_

Last

First

M.

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Month/year of Birth: \_\_\_\_\_

Home phone # \_\_\_\_\_ Cell phone #: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Name of School: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone # \_\_\_\_\_

Do you have a Mentor:  Yes  No Name of Mentor: \_\_\_\_\_

Facility Location of Shadow:  *Albuquerque*  *Santa Fe*  *Española*  *Socorro*  *Tucumcari*  *Clovis*  *Ruidoso*

Department: \_\_\_\_\_ Dates of Shadow: \_\_\_\_\_ Total Hours: \_\_\_\_\_

Dates and times available (Job Shadow w/out Identified Mentor): \_\_\_\_\_

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## Acknowledgments

I, \_\_\_\_\_ hereby acknowledge my willingness to participate in the Student Job Shadow Program at Presbyterian Healthcare Services (PHS).

### Release of Liability:

I recognize that job shadowing in the workplace can provide a valuable educational experience for me. I understand that there are numerous risks to health and safety within the healthcare setting and I voluntarily assume all risks associated with my presence in a PHS facility as a job shadower. I also understand that I am only to observe and **not** to assist with providing patient care of any kind.

I hereby release PHS, its officers, directors, employees, affiliates, and agents from any and all claims, demands, damages, or liabilities in any way arising from or related to my presence as a job shadower in any PHS facility.

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## Confidentiality/HIPAA

I understand that during my job shadow assignment I may come in contact with confidential or information protected by the Health Information and Accountability Act (HIPAA) related to patients and members, business operations, and personnel. This includes what I may overhear, or individuals I may see, in any PHS facility. I agree not to divulge or disclose any confidential information acquired as a result of my assignment to anyone other than those persons at PHS who have a legitimate “need to know.” I further understand that posting information and/or photos on social media is strictly prohibited.

Access, disclosure, or unauthorized use of confidential information is prohibited and will result in my immediate termination as a job shadower, and I will not be able to complete any further observation experiences with PHS. Additionally, I understand the severity of HIPAA violations and potential legal consequences. Information that is considered confidential or HIPAA-protected includes, but is not limited to the following:

- Written records (i.e., medical records, schedules, forms, etc.)
- Information accessed through computers
- Verbal communications (with staff, patients, members, and visitors)

## Handbook/Personal Protective Equipment/Badge

Once admitted to the PHS Student Job Shadow Program, I acknowledge that I will read a copy of the Presbyterian Healthcare Services Job Shadow Handbook, which summarizes the Pipeline Program requirements, including HIPAA Privacy, Fire & Safety, Infection Control, Dress Code, and how to report Work Injuries. I will also read and agree to adhere to the PHS *Tobacco-Free Environment* and *Drug & Alcohol Abuse and Testing* policies as part of the PHS Student Job Shadow Program orientation and training.

I also acknowledge that some departments may require the additional use of personal protective equipment (PPE) that is considered a mandatory part of the Dress Code. I will abide by wearing all required PPE and understand that if such PPE is required, it will be provided by the department. Examples of PPE include, but are not limited to the following:

- Protective clothing, helmets, gloves, face masks, goggles, face shields and/or respirators or other equipment designed to protect from injury or the spread of infection or illness.

In addition, I agree to only wear my PHS-issued badge during approved job shadow hours. This badge is to be returned to Human Resources, or my identified mentor, upon completion of approved job shadow hours. I understand that if I do not return the badge to Human Resources, it will affect future job shadow opportunities with PHS.

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### Applicant Signature

*The above information is accurate and correct to the best of my knowledge. By signing this application, I agree to abide by all PHS Student Job Shadow Program rules and expectations and understand this will be an observation-only experience and I am not to provide any patient care. I will maintain in strict confidence (and according to HIPAA) all information obtained as a result of my job shadow assignment regarding patients, members, visitors, and staff.*

Print Name: \_\_\_\_\_

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

**If you are under 18 years of age, your parent or legal guardian must also read and acknowledge this form.**

### Parental Consent Signature

Name of Parent/Legal Guardian: \_\_\_\_\_

Signature of Parent/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_