HIGH SCHOOL STUDENT JOB SHADOW

Please provide the following forms:

- Job Shadow Information Sheet
- Healthcare Career Interest Sheet
- Affirmation and Release of Liability over/under 18
- School Counselor Recommendation/Permission Form
- Understanding of Healthcare Confidentiality
- Dress Code
- HIPAA exam and essay after you view the HIPAA PowerPoint
- A copy of your immunization/flu records. Flu record must be provided if shadowing between November 1st and April 1st

We will do our best to accommodate your schedule while setting up your shadow. Times are typically 9:00am-11:00am or 1:00pm-3:00pm.

ALL CORRESPONDENCE CONCERNING YOUR SHADOW WILL BE PROVIDED THROUGH E-MAIL.

JOB SHADOW PROGRAM POLICIES

AGE LIMITS:

In order for a student to participate in the Genesis Job Shadow Program, they must be currently enrolled as a Junior or Senior in high school and be 16 years old.

REMINDERS:

- Follow the job shadowing dress code.
- No cell phones or texting during your shadow experience.
- You must provide your own transportation to your host site.
- Plan your travel time accordingly so that you arrive at your shadow site on time.
# Student Information Sheet

## General Information - Print Legibly

Name: ____________________________  Date of Birth: ______________ Age: ______

Address: __________________________ City, Zip: ______________________

Phone: ____________________________ Email: ____________________________

High School: ________________________ Grade: __________ Counselor: ______________

Caucasian  African American  Native American  Hispanic  Asian  Other

Female ___  Male ___

## Emergency Notification:

Name: ____________________________

Relationship: ______________ Phone: ____________________________

## Return Forms To:

**VIA US POST OFFICE:**
LEARNING AND DEVELOPMENT
1227 EAST RUSHOLME ST.
DAVENPORT, IA 52803

**SCAN AND E-MAIL TO:**
ADAMSN@GENESISHEALTH.COM

**FAX APPLICATION TO:** 563-421-2281

ALL CORRESPONDENCE REGARDING YOUR JOB SHADOW WILL BE SENT BY E-MAIL

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High School Student
# HEALTH CARE CAREER INTERESTS

**PLEASE NUMBER IN ORDER OF PREFERENCE (1-3)**

<table>
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<th>NAME: __________________________________________________________________</th>
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**Nursing:**
- OB: ____
- Neurology/Oncology: ____
- Pediatrics: ____
- Pre/Post Surgical: ____
- Ortho: ____
- Rehabilitation: ____
- Emergency Room: ____
- Cardiac Rehab: ____
- Hospice: ____

**Therapy:**
- Occupational Therapy_____
- Physical Therapy_____
- Cardiac Rehab_____
- Recreation Therapy_____
- Speech Therapy_____
- Respiratory Therapy_____
- Radiation Therapy_____

**Other:**
- Social Work____
- Ambulance____
- Bio Medical Technician____
- Culinary arts/food____
- Pharmacy____
- Radiology____
- Laboratory____

**PERSON YOU WOULD LIKE TO SHADOW, IF KNOWN:** ____________________________

You must have prior approval from a physician in order to shadow a physician. Typically medical staff will reach out on behalf of a student interested in shadowing.

## DATES

Please provide three dates and times that you are available to job shadow. (Include weekends)

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<th>Time (Circle One):</th>
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AFFIRMATION AND RELEASE OF LIABILITY

(STUDENT UNDER 18 YEARS OF AGE)

I, ____________________________________________, the parent and/or legal guardian of ____________________________, a minor child, hereby acknowledge that I am cognizant of and understand that there are inherent dangers in my child participating in the Genesis Job Shadow Program located within Genesis Health System, which include, but are not limited to, my child encountering experiences which may be relatively new and may be taxing on my child’s senses and exposed to an environment that has sick and injured patients.

I hereby give permission for my child to participate in the Genesis Job Shadowing Program at Genesis Health System. In consideration of my child being allowed to participate in this program, I, on behalf of myself, my personal representatives, heirs, spouse, parents, siblings and children, hereby:

1. Assume all risk of injury, death or property damage in connection with any of the above mentioned activities, situations and my child's presence at any of the facilities of Genesis Health System.

2. Release, waive, discharge, and covenant not to sue Genesis Health System, its administration, board of directors, employees, and agents (referred to as the Released Parties) from any and all liability related to my child's participation in the Genesis Job Shadow Program at Genesis Health System.

3. Agree to indemnify, save and hold harmless the Released Parties, and each of them, from any loss, liability, damage or cost (including, but not limited to, reasonable attorneys' fees and other defense costs incurred) one or more of them may incur arising out of or related to my child's participation in the Genesis Job Shadow Program at Genesis Health System.

4. Agree that this Affirmation and Release of Liability extends to all claims of wrongful acts of the Released Parties, whether sounding in tort, contract or other legal theory, and that this Affirmation and Release of Liability is intended to be as broad in scope as is permitted by the laws of the State of Iowa. I further agree that in the event that any portion of this Affirmation and Release of Liability is held invalid, the remaining provision shall, notwithstanding, continue in full legal force and effect to the greatest extent possible under Iowa Law.

I hereby give my consent to Genesis Health System, its physicians, staff, employees and volunteers to obtain medical care from any licensed physician, hospital or clinic, including transportation and emergency medical services, for my child for any injury arising from his or her participation in the Genesis Job Shadow Program at Genesis Health System. I understand that I am financially responsible for all charges for any such medical care.

I further state that I am the parent and/or legal guardian of the child, listed above and I am of lawful age. I am competent to sign and have read this Affirmation and Release of Liability form and understand its terms. I understand that the terms of this Affirmation and Release of Liability are contractual and not a mere recital; and that I have signed this document freely and voluntarily without any inducement, assurance or guarantee being made to me and I intend my signature to be a complete and unconditional release of all liability to the greatest extent allowed by Iowa law.

__________________________________________  ________________________________________  ____________
Print Parent’s Name                      Print Child’s Name                      Date

__________________________________________
Parent’s Signature

High School Student
AFFIRMATION AND RELEASE OF LIABILITY

(/student 18 years of age or older)

I, ____________________________________, hereby acknowledge that I am cognizant of and understand that there are inherent dangers in my participating in the Genesis Student Shadow Program located within Genesis Health System, which include, but are not limited to, my encountering experiences which may be relatively new and may be taxing on my senses and being exposed to an environment that has sick and injured patients.

In consideration of my being allowed to participate in this program, I, on behalf of myself, my personal representatives, heirs, spouse, parents, siblings and children hereby:

1. Assume all risk of injury, death or property damage in connection with any of the above mentioned activities, situations and my presence at any of Genesis Health System.

2. Release, waive, discharge and covenant not to sue Genesis Health System, its administration, board of directors, employees, and agents (referred to as the Released Parties) from any and all liability related to my participation in the Job Shadow Program at Genesis Health System.

3. Agree to indemnify, save and hold harmless the Released Parties, and each of them, from any loss, liability, damage or cost (including, but not limited to, reasonable attorneys' fees and other defense costs incurred) one or more of them may incur arising out of or related to my participation in the Job Shadow Program at Genesis Health System.

4. Agree that this Affirmation and Release of Liability extends to all claims of wrongful acts of the Released Parties, whether sounding in tort, contract or other legal theory, and that this Affirmation and Release of Liability is intended to be as broad in scope as is permitted by the laws of the State of Iowa. I further agree that in the event that any portion of this Affirmation and Release of Liability is held invalid, the remaining provisions shall, notwithstanding, continue in full legal force and effect to the greatest extent possible under Iowa law.

I hereby give my consent to Genesis Health System, its physicians, staff, employees and volunteers to obtain medical care from any licensed physician, hospital or clinic, including transportation and emergency medical services, for me for any injury arising from my participation in the Genesis Job Shadow Program at Genesis Health System. I understand that I am financially responsible for all charges for any such medical care.

I further state that I am at least eighteen (18) years of age and that I am competent to sign and have read this Affirmation and Release of Liability form and understand its terms. I understand that the terms of this Affirmation and release of Liability are contractual, and not a mere recital; and that I have signed this document freely and voluntarily without any inducement, assurance or guarantee being made to me and I intend my signature to be a complete and unconditional release of all liability to the greatest extent allowed by Iowa law.

____________________________________  ______________________________________  _______________
Print Name  Signature  Date

High School Student
SCHOOL COUNSELOR RECOMMENDATION

TO BE COMPLETED IF YOU ARE SHADOWING DURING THE SCHOOL YEAR

Date: _______________________

________________________________________

__________________________ has the permission of __________________________ High School to participate in the Genesis Job Shadow Program. This student is in good academic standing and will adhere to all job shadowing policies.

________________________________________

Counselor Name (please print)                     Counselor Signature

________________________________________

Counselor e-mail                             Counselor Phone Number

High School Student
UNDERSTANDING OF HEALTH CARE CONFIDENTIALITY

(REQUIRED BY IOWA AND U.S. FEDERAL LAW AND GENESIS HEALTH SYSTEM)

As a participant in the Student Job Shadow Program at Genesis Health System, I, the undersigned, hereby acknowledge that I have the responsibility for maintaining strict confidentiality of information shared with me or acquired by me as a part of my shadow program and access at Genesis Health System. Anything that I learn while participating in the shadow program that relates to patients, patient information, computer passwords, confidential information about an employee, physician, or management and any and all financial information regarding Genesis Health System is for my authorized use only while I am participating in the shadow program. I understand that such information may be discussed only as needed to perform the duties and responsibilities, if any, of the student shadow program.

I understand that I may not disseminate, convey, send, transmit, post or otherwise transfer anything that I learn in the course of my participation as a student shadow that involves any patient information, computer passwords, confidential information about an employee, physician, volunteer, other student in the shadow program or management and any and all financial information regarding Genesis Health System to anyone by any means, including, but not limited to, text messaging, instant messaging, email, cell phone, any social media (Facebook, MySpace, Twitter, etc.), whether currently in existence or developed in the future, and whether by words or in photographs.

In consideration of my participation in Student Job Shadow Program at Genesis Health System, I hereby agree, pledge and undertake that I will not, at any time during my participation in the shadow program with Genesis Health System, or at any time after my participation ends, access or use personal health information, or reveal or disclose to any persons or entities within or outside of Genesis Health System, any personal health information except as may be required in the course of my participation and in accordance with all applicable legislation, corporate and departmental laws, rules, regulations or policies governing the release of information.

If I do not know whether or not I am allowed to discuss access or use any information that I have learned as a participant in the shadow program, I will ask an adult leader in the shadow program before doing so.

I understand that my obligations outlined above will continue after my participation in the shadow program with Genesis Health System ends and, I further understand that my obligations concerning the protection of the confidentiality of personal health information relate to all personal health information, that I have acquired through my participation in the shadow program with Genesis Health System or within any of the healthcare facilities owned or managed by Genesis Health System.

I also understand that unauthorized use or disclosure of confidential information will result in corrective action up to and including, but not limited to termination of participation in the shadow program with Genesis Health System and the imposition of sanctions or fines pursuant to Iowa and Federal Laws.

__________________________________________________________________________  ______________________________________________________________________
Print Name                                                                 Date

__________________________________________________________________________
Signature

High School Student
DRESS CODE-BUSINESS CASUAL

- Khaki, black or blue dress pants
- NO JEANS
- Participants must dress modestly and neatly with shirt tucked into pants.
- Please avoid extreme dress, hairstyles and jewelry.
- Do not wear clothing such as T-shirts that portrays suggestive or derogatory pictures and messages, including advertising of alcohol, tobacco, etc.
- Clothing should cover all undergarments.
- No sleeveless blouses, shirts or tops.
- Clothing should not be skin tight or revealing.
- No bare skin showing when bending over or stretching.
- No eyebrow, nose, tongue, or lip piercings allowed during your shadow.
- Body tattoos must be covered during shadowing hours.
- Wear flat comfortable walking shoes- no sandals or open-toed shoes.

I understand and agree to abide by the Genesis Job Shadowing Dress Code.

__________________________________________________________
STUDENT (PLEASE PRINT)  STUDENT SIGNATURE  DATE

__________________________________________________________
PARENT SIGNATURE  DATE

(IF STUDENT IS UNDER 18)
NAME: _______________________________________________________

1. HIPAA is Federal law that requires confidentiality.
   □ True
   □ False

2. Of the following behaviors, which one is appropriate for a person completing a job shadow?
   A. Asking the physical therapist you are shadowing how much money he/she makes in a year.
   B. Asking questions to gain a better understanding about a healthcare profession.
   C. Using your cell-phone to take pictures while shadowing.

4. HIPAA must be followed by ALL health care professionals/volunteers/job shadowers.
   □ True
   □ False

5. Violations of patient privacy may have the consequences of jail time and/or fines.
   □ True
   □ False

6. It is permissible to talk about patients as long as I do not use their name.
   □ True
   □ False

7. The following are all examples of business casual except:
   A. Khaki or black dress pants
   B. Polo shirt
   C. Nose piercing

8. Job shadowing allows you to get a first-hand perspective of what professionals do on a "typical day."
   □ True
   □ False

9. Asking questions while shadowing communicates your level of interest and shows you are engaged in this learning experience. You should come prepared with 3 questions.
   □ True
   □ False

10. HIPAA stands for Health Information, Privacy & Awareness Act.
    □ True
    □ False

11. If you see a person you know while job shadowing:
    A. Say “hi” and move on.
    B. You may ask why they are there.
    C. It’s okay to tell your family and friends.
    D. Text a friend to let them know.

While job shadowing, you are representing yourself, your teacher, and your school. You should remember to act in an appropriate manner at all time.

High School Student
Genesis
Job Shadow Program
Job Shadow

• A job shadow is an “observation only” experience in which a person can learn more about a specific healthcare career.

• Makes a connection between what you are leaning or have learned in the classroom to the work environment.

• Gives a glimpse of a “typical day” of a healthcare professional.

• Provides an opportunity for a questions about your future and potential career.
Did you know?

1 out of every 4 jobs will be related to or in the healthcare field in the next 10 years.
Ask questions when you shadow

Develop a list of at least 3 questions to ask during your shadow

- What are the skills needed to do your job?
- What does a typical day look like?
- What do you like most about your job?
- Why did you choose this career?
What to wear

• Black or khaki colored pants (no jeans or shorts)
• Collared shirt/sweater
• Clean, comfortable shoes – no open toes or sandals
• Tattoo must be covered
• Lip, Eye, Nose, and Tongue piercings removed
HIPAA

HIPAA stands for Health Insurance Portability and Accountability Act

- It is a federal privacy law that health professionals **MUST** follow in order to keep a patient’s medical information confidential
- These regulations must be followed by **EVERYONE** including any volunteers and visitors to a healthcare facility that provides care to patients
Patient Care & HIPAA

- Patients have the right to be treated confidentially in a healthcare facility.

- If a patient withholds health information due to not trusting their healthcare provider, proper care may not be given.
Patient Rights

- Healthcare providers that treat patients over 18 are not legally able to discuss any information unless given permission to do so.
If you see someone you know

• Greet them with a smile, say hello and move on

• Do not share any information about who or what you saw during your shadow with anyone or on social media
HIPAA violations

- Consequences can range anywhere from $100 fine to jail time
- Employees can lose their job for violating HIPAA
- Genesis employees, volunteers, job shadowers are required by law to keep patient information confidential.
- More importantly, **YOU** are required by law to keep patient information confidential
HIPAA Essay and Exam

- HIPAA Essay
  - Why is HIPAA important? How does HIPAA impact your JS experience?
  - 300 words or less

- HIPAA/Job Shadow Exam
  - Please complete exam and return with application
  - Exam