Greater Regional HEALTH

Job Shadow/Observation Request Form

Form must be submitted 30 days prior to the shadow/observation request dates. Submission does not guarantee placement. Processing may take up to 15 days. To cancel your job shadow/observation, email amyr@greaterregional.org or call 641-782-3695. Individual departments will determine if it can be rescheduled. *A flu shot is required for all job shadow/observation requests.

Student Name Information

Name		
Email		Date of Birth:
Phone		Grade in School:

Outreach Contact

School	
Email	

Contact	
Phone	

Emergency Contact

Name	
Email	

Relationship	
Phone	

Department or Area of Interest

What department would you like to shadow/observe?

If you have been in contact with a GRH employee regarding shadowing/observing, provide name and department.

Provide a minimum of three date and time possibilities

1) 2) 3) 4) 5)

Please provide a 150-200 word statement explaining why you are interested and what you hope to gain in shadowing/observing.

By checking the boxes below, I am verifying that I meet this criteria.

❑ Submit copy of immunizations as part of your application. If this is not received, you will not be able to participate, and your application may be closed without notification.
❑ I received an influenza Vaccine for the current season (Mandatory during active flu season)
❑ I received a COVID Vaccine
❑ The information provided on this application is true and complete to the best of my knowledge. I verify I have received, read, and understand the KnowBe4 Training outlining the following policies and procedures:

a. Confidentiality and HIPAA
b. Infection Prevention
c. Personal Protective Equipment
d. Safety
e. Professional Conduct
f. Professional Appearance

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CONSENT AND RELEASE FORM

In consideration of the opportunity to voluntarily participate in a learning program at Greater Regional Health, I agree to the following:

1. I certify that I am at least fourteen (14) years of age or older.
2. I understand that patients undergoing examination, procedure or treatment must consent to my presence.
3. I agree to maintain and protect the absolute confidentiality of the names of the patients and any other patient identifying information, as well as all information relating to the condition, diagnosis and treatment of any patient of which they become aware during the course of observation.
4. I understand that this is an observation only experience. I agree not to provide care of any kind to any patient or to write on any patient's medical record.
5. I understand that Greater Regional Health will not assume nor provide any type of insurance coverage, including malpractice insurance coverage, for me while I am on hospital premises.
6. I will conduct myself in a professional manner
7. I understand that I will, at all times, remain in the presence of the individual whom I am interviewing or observing. I will leave the patient care areas when the interview or observation is complete and the hosting individual(s) leave.
8. I acknowledge that no assurance or representation concerning my health or safety during the period of my voluntary interview or observation experience have been made to me. I understand that numerous risks to health and safety may be present in a hospital, including but not limited to personal injury or exposure to infectious agents, and I voluntarily assume all risks associated with my presence in the hospital as an observer.
9. I understand that Greater Regional requires that its employees, invited guests and observers have the appropriate immunizations. I further understand that my failure to obtain and/or show proof of these immunizations prior to an in-person observation experience will result in its termination.
10. I understand that Greater Regional Health reserves the right to terminate the voluntary interview or observation experience at any time.

I hereby release Greater Regional Health, its parent, affiliates, and subsidiaries, its medical staff, physicians, directors, officers, employees, agents and representatives from any liability, injury or damages caused by or arising from or in connection with my presence as an observer or learner in the hospital.

By voluntarily signing below, I acknowledge that I have read this Agreement and will comply with all terms and conditions stated.

____
Observer's Name (please print)

____
Individual Being Observed (please print)

____
Signature of Observer

____
Witness Signature

____
Date of Observation

____
Date of Signature

____
Signature of Parent/Legal Guardian if under 18 years old

____
Person to Notify in Case of Emergency