Shadowing/Observer Application

PLEASE READ AND FOLLOW THESE INSTRUCTIONS:

- ❒ **Complete and sign ALL forms in this packet and EMAIL to learningresources@gwinnettmedicalcenter.org.**
  - **All shadowing requests are processed through email only. This ensures we have your correct email address for all communication. If you do not have access to a scanner, take pictures of your application and email the JPG files.**
  - You must provide a physical signature. **A digital signature will not be accepted.**
  - Allow 7 business days for processing. Shadowing is for a maximum of **two days**.
  - **You are responsible for locating an associate/physician/midlevel to shadow.**

Student Personal Information

Name:		☐ I am at least 18 years of age or older	
Address:		City:	Zip
Cell Phone:	Email Address:	Are you related to an employee? ☐ Yes ☐ No If so, who:	

Educational Information

Name of Your School: Are you a Medical Student? ☐ Yes ☐ No	Are you in or accepted to an academic program? ☐ Yes ☐ No If so, what is the name of the program?
What is your purpose for shadowing? ☐ To explore a possible health care career. ☐ To fulfill an educational requirement in a ***currently enrolled*** program. ☐ To fulfill an ***application requirement*** for a professional program.	In what department do you need to shadow? If **Rehabilitation**, which area? ☐ Physical Therapy, ☐ Occupational Therapy, or ☐ Speech Therapy If **Radiology**, which area? ☐ Imaging, or ☐ Ultrasound
What is the best date and time for you to shadow? Have you shadowed before with us? ☐ Yes ☐ No If "yes", when?	**Anesthesia and Radiology are ONE DAY ONLY experiences.**
What is the name of associate/physician/midlevel who will be **emailing approval** for you to shadow? (Not required for Anesthesia, Radiology or Rehabilitation)	

Shadowing/Observer Behavioral Agreement

☑ As a condition of my affiliation with Gwinnett Health System (GHS), in a shadowing/observer role, I agree to restrict my activities to shadowing/observational only.

☑ I will not participate in patient care in any way, or interact with GHS technology, equipment, or supplies.

☑ I understand GHS has a legal and ethical responsibility to safeguard all patients. If at any point a GHS associate feels the patients' care is compromised, I can be asked to leave the facility.

☑ I understand cellphones are only allowed when on breaks in the designated breakroom areas.

_____ _____

Signature of Participant **DATE**

_____

Participant Printed Name

_____

School Represented

Communicable Disease Disclosure Form

At the time of my shadowing experience, I declare that I am free from any of the following communicable diseases to the best of my knowledge:

- ☑ Fever > 100 degrees.
- ☑ Vomiting
- ☑ Diarrhea
- ☑ Conjunctivitis
- ☑ Open weeping lesion/s
- ☑ Uncontrollable cough
- ☑ Uncontrollable cough
- ☑ I am aware that if I experience a medical emergency during my shadowing experience, I will immediately be taken to the emergency room. I will be responsible for all medical bills for treatment that are incurred.

Flu Declaration (check one):

- ❒ If shadowing during flu season, November 1 through March 31, **I attest to having a flu shot**.
- ❒ I will be shadowing during flu season, November 1 through March 31, and have not had a flu shot. **I will wear a mask** while onsite for my shadowing time period.
- ❒ I will not be shadowing onsite during flu season, November 1 through March 31st.

I have carefully read this agreement and understand its contents.

_____ _____

Signature of Participant **DATE**

Magnetic Resonance Imaging (MRI) Form

All MRI suites maintain a safe environment by: restricting access to all MRI work areas; requiring modified GMC identification badges for associates who may not safely enter the MRI area; and screening "all" associates, patients, family members, and affiliates (i.e. students and faculty) prior to entering the MRI suite for pacemakers, aneurysm clips, permanent tattoos, body piercing, hemostats, pagers, and more.

Students or faculty who have experiences in the MRI area need to be thoroughly screened and cleared to enter the area using the **MRI Safety questions below.**

Please check your answers and then sign this form below.

MRI Safety Questions	
1. Have you ever been hit in the face with a piece of metal (including metal shavings, slivers, rust, BB's or bullets)?	☐ Yes ☐ No
2. Have you ever worked as a machinist or welder?	☐ Yes ☐ No
3. Have you ever had metal removed from your eye?	☐ Yes ☐ No
4. Do you have any metal in your body from an accident (including pencil points,	☐ Yes ☐ No
5. Have you ever had eye surgery (other than LASIK surgery)?	☐ Yes ☐ No
6. Do you have any surgically implanted metal (including an intrauterine device, catheters, tubes, stints, or valves)?	☐ Yes ☐ No
7. Do you have or have you ever had a pacemaker, pacemaker wires, defibrillator or cardiac	☐ Yes ☐ No
8. Do you have a brain/aneurysm clip?	☐ Yes ☐ No
9. Do you have an eye/ear implant or hearing aid?	☐ Yes ☐ No
10. Do you have an electrical stimulator for nerves or bones?	☐ Yes ☐ No

My signature below validates I have answered the above questions candidly, and if I have answered "Yes" to any of the above questions, I agree to notify MRI staff prior to entering any MRI Suite at GMC for my personal safety.

_____ _____

Signature of Participant **DATE**

Workforce Confidentiality Agreement

I understand that Gwinnett Health System, Inc. (GHS) has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their health information.

I understand that during the course of my employment or other affiliation with GHS, I may see or hear other confidential information such as financial data and operational information pertaining to the activities that GHS is obligated to maintain as confidential.

I am aware that confidentiality and information security training is required for members of GHS' workforce, and I agree to complete this mandatory training. I agree to follow all GHS policies and procedures.

I will not access or view any information, including my own or family members, other than what is required to do my job. If I have any question about whether access to certain information is required for me to do my job, I will immediately ask my supervisor for clarification.

I will not discuss any information pertaining to GHS or its patients in an area where unauthorized individuals may hear such information (for example, in hallways, on elevators, in the cafeteria, on public transportation, at restaurants, or at social events). I understand that it is not acceptable to discuss any information in public areas even if specifics such as a patient's name are not used.

I will not make inquiries about any information for any individual or party who does not have proper authorization to access such information.

I will not make any unauthorized transmissions, copies, disclosures, inquiries, modifications, or purgings of information. Such unauthorized transmissions include, but are not limited to removing and/or transferring information from GHS' computer system to unauthorized locations (for instance, home).

I agree that I will report promptly any known or suspected violations of GHS' confidentiality and information security policies and procedures to GHS' Privacy Officer or their designee.

Upon termination of my employment or other affiliation with GHS, I will immediately return all property (e.g. keys, documents, ID badges, etc.) to GHS.

I agree that my obligations under this agreement regarding information will continue after the termination of my employment or other affiliation with GHS.

I understand that violation of this agreement may result in disciplinary action, up to and including termination of my employment or other affiliation with GHS and/or suspension, restriction or loss of privileges, in accordance with GHS' policies, as well as potential personal civil and criminal legal penalties.

I have read and understand this agreement and will comply with all its terms.

_____ _____

Signature of Participant **DATE**

_____

Participant Printed Name

2019 Information Security Training: Acknowledgement Statement

Please complete this form after you have reviewed the **Information Security 2019 Self-Study.**

☐ Yes	☐ No	1.	PHI stands for Protected Health Information.
☐ Yes	☐ No	2.	The following organizations are responsible to protect PHI: healthcare provider, health plan, and healthcare clearinghouse.
☐ Yes	☐ No	3.	PHI relates to a patient's: past, present or future of physical or mental health condition or payment for healthcare.
☐ Yes	☐ No	4.	The GHS policy regarding access and/or disclosure of patient's PHI is based on the following rule: minimum necessary.
☐ Yes	☐ No	5.	If you are asked for information about a "No Information" patient you should reply "I have no information on a patient by that name".
☐ Yes	☐ No	6.	All security failures are of one of two types: intentional attack and workforce member carelessness.
☐ Yes	☐ No	7.	An example of a strong password is "Welc0m3!".
☐ Yes	☐ No	8.	Social networking is not the place to post patient information, corporate critique, or photos of what you did at work.

I have read the Information Security 2019 Self Study and will comply with all its terms.

_____ _____

Signature of Participant **DATE**

_____

Participant Printed Name

CLINICAL SHADOWING EXPERIENCE
Wavier

This is a release of liability. Please read before signing. Do not sign or initial the release if you do not understand or do not agree with its terms.

1. I, _____ , have asked to participate in a clinical shadowing experience at (check one):
   - ☐ Gwinnett Medical Center- Lawrenceville Facility
   - ☐ Gwinnett Medical Center- Duluth Facility
   - ☐ Duluth Outpatient Center
   - ☐ Glancy Rehabilitation Center
   - ☐ Community Clinics

2 I understand that while shadowing in the clinical setting of the hospital, I may be exposed to the risk of bloodborne pathogens, communicable diseases such as tuberculosis, radiation, chemical hazards and the risk of a fall which can result in personal injury. I understand that GHS takes reasonable precautions related to these hazards.

3. I expressly assume the risk of personal injury which may result from my participation or my minor child's participation in the above activity. I waive any claims based on negligence I might assert on my own behalf or on behalf of my minor child.

4. I further agree to hold Gwinnett Hospital System, Inc., its agents, and employees harmless and to indemnify them for personal injuries which result from my own participation or my minor child's participation in the above activity.

5. This agreement shall be legally binding upon heirs, legal guardians, personal representatives, and me.

I have carefully read this waiver and by signing agree to its contents.

_____ _____

Signature of Participant **DATE**

_____

Participant Printed Name