# Shadowing Experience Application

**Minimum eligibility requirements:**

- 16 years of age
- Able to articulate learning objectives
- Willing to adhere to professional appearance and behavior guidelines
- Free of exposure to infectious disease in the 14 days prior
- COVID and influenza vaccinations

Name: _____ Birth Date: _____

E-Mail Address: _____

Home Phone: _____ Cell Phone: _____

Address: _____
Street City Zip

School: _____ Grade: _____

Are you requesting to shadow a nurse? ☐ Yes ☐ No

If no, what healthcare position do you wish to shadow?_____

What department(s) interest you? _____

How many hours do you desire?_____Do you know an associate you wish to shadow with? ☐ Yes ☐ No

If yes, Associate name: _____

What do you hope to gain from this experience? ☐ School/Application Pre-Requisite ☐ Career Discernment
☐ Personal Interest ☐ Other *(specify)* _____

☐ *(Initial)* I understand I must provide proof of immunizations, including Mumps, Measles, Rubella, Hepatitis B, Varicella, Tetanus, and a negative TB skin test (within the past 2 years for all non-associates). (If you do not have a current TB test, see your physician to complete this requirement.) I attest I have not been in contact with persons who have infectious TB within the last 10 weeks and further attest I have no signs of active TB. **Attach

☐ *(Initial)* I understand I must provide proof of both my current annual influenza vaccination and COVID-19 vaccination with the understanding that I will comply with Facility's policies regarding intervention with patients and staff which will include requiring me to wear a mask. (If you do not have a current flu and COVID-19 vaccine, see your physician or clinic to complete this requirement.) **Attach the documentation to this application **PRIOR TO APPLYING FOR THE SHADOW EXPERIENCE.**

***This applies to individuals 18+ years of age only:***

☐ *(Initial)* I understand upon confirmation of the shadow experience, I must provide a current criminal background check, which must include a National Criminal Database Search with nation-wide Registered Sex Offender search and Healthcare Sanctions (OIG/GSA), Office of Inspector General (OIG) Search, at my own expense, with the understanding I will not receive reimbursement for such cost from Advent Health or any of its facilities.
**Please provide the documentation ***UPON RECEIPT OF THE DATE AND TIME OF THE SHADOW EXPERIENCE.***

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In case of emergency: _____ _____

Contact Name Contact Phone

*When I shadow, I will honor the confidentiality of the patients, associates and business of Advent Health and all of its facilities. I will not mention or discuss patients within the facility or away from the facility. I agree to follow the policies of Advent Health during this shadowing experience. I understand this shadowing experience will not exceed 3 days. I also understand this experience is to observe only and I will not be touching patients nor providing any care to patients. If I am injured during my shadow experience, my personal health insurance will be billed. It is a privilege to observe business and patient care activities at Advent Health and its facilities, and I agree to follow the directions and guidance of the associate I am shadowing. I further understand in order to participate in a shadow experience, my current criminal background check must be approved.*

_____ _____

Signature of Applicant Date

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*If the applicant is under the age of 18, the parent/legal guardian signature below indicates your approval and support of your child's application to shadow at any Advent Health facility.*

*In case of injury, permission is granted to Advent Health to give emergency care, if necessary. I understand my child is not covered by Advent Health's workers' compensation policy and if injured, my minor child's personal health insurance will be billed.*

_____ _____

Parent/Guardian Signature Date

## SHADOWING AGREEMENT WAIVER, RELEASE & CONFIDENTIALITY STATEMENT

In consideration of participating in an educational shadowing experience with Advent Health, I indemnify Advent Health and all its facilities and hold harmless its subsidiaries, representatives, agents and employees from liability, which may result from my participation. I will not bring nor cause to be brought on my behalf any legal action against Advent Health.

Recognizing that my educational shadowing experience provides access to a variety of information deemed strictly confidential, I accept that it is the patient's right to refuse permission for me to observe the delivery of medical care or services delivered to that patient. I acknowledge my obligation to maintain the confidentiality of all information which I may possess as a result of the shadowing experience and that disclosing such information is prohibited and unethical.

I acknowledge the risk that medical and surgical procedures may include graphic and shocking images along with explicit discussion of the human body. I acknowledge and assume the risk that patients, physicians, nurses and others involved with the delivery of medical care may unknowingly expose me to infection and/or illness.

It is my voluntary decision to participate in this educational experience and agree to conduct myself in an appropriate manner, to take direction from appropriate personnel and to dress in a professional manner.

**Further, I acknowledge that this shadowing agreement does <u>not</u> authorize me to perform patient care, and that the unauthorized performance of patient care shall result in my automatic removal from the facility.**

Shadower Name:_____
(Please Print)

Shadower Signature:_____

Date:_____

Email Address:_____
(Please Print)

# Shadowing Experience Application

*If the applicant is under the age of 18, the parent/legal guardian signature below indicates your acknowledgment and agreement to the terms of the Waiver, Release and Confidentiality Statement above, on behalf of your child.*

*In case of injury, permission is granted to Advent Health to give emergency care, if necessary. I understand that my child is not covered by Advent Health*

*'s workers' compensation policy and if injured, my minor child's personal health insurance will be billed.*

_____ _____

Parent/Guardian Signature Date