# Observer / Job Shadow Agreement Form
# SECTION I: Request to Job Shadow a HSHS Colleague

## Observer Request:

**Name: _____ Phone Number: _____-_____-_____**

**Email:_____**

**Address: _____**

**City: _____ State: _____ Zip Code: _____**

**School/Organization: _____**

**Observation Date(s): From ____/____/_____ To ____/____/_____**

**HEALTH REQUIREMENTS: Documentation of the following to be kept on file with People Services Department:**

1. **Proof of immunity to Rubella, Rubeola and Mumps, regardless of age**

   - ❑ **Documented history of 2 MMR's OR Documentation of positive Rubella, Rubeola, and Mumps titre**

2. **Proof of TB skin test done within the last 12 months with negative results**

   - ❑ **If TB skin test positive, documented report of a negative chest x ray must be on file. In addition, TB symptom survey must be on file and updated annually.**

3. **Proof of immunity to Varicella**

   - ❑ **Documented history of 2 Varicella vaccines OR Positive Varicella titre OR Documented history (from a healthcare provider) of chicken pox or shingles**

4. **Proof of influenza vaccination for the current influenza season for any observer who is in a HSHS's facility for at least 1 day of their observational period between October 1 and March 31.**

   - ❑ **Documented history of annual influenza vaccines**

**Sponsor: _____ Sponsor Phone Number: _____-_____-_____**

**Sponsor Email: _____**

**Name of Ministry - Observational Site:**
**_____**

**Department/Unit/Practice where observation will occur:**
**_____**

**Reason for observation:**
**_____**

***Reminder:*** *Sponsor is responsible for notifying applicable Leader prior to conducting job shadow experience.*

## SECTION II: Individuals Observing an HSHS Colleague

HSHS has agreed to allow selected persons to shadow professionals. In consideration of HSHS's allowing individuals the opportunity to job shadow at HSHS's the individual hereby agrees to the following:

**Privacy/Confidentiality** - The individual agrees any patient health information or knowledge acquired or received during the course of the job shadow at HSHS's, including but not limited to patient care information and information contained in patient care records, shall be treated as confidential and shall not, unless required by law or otherwise permitted by HSHS's, be disclosed or used during or after termination of the individual's placement at HSHS's without HSHS's prior written consent.

**Release/Indemnification -** The individual agrees to and hereby does release, indemnify and hold harmless HSHS'S, its members, directors, officers, colleagues and representatives from any and all responsibility and obligation, and agrees not to hold HSHS's liable for any or all injuries, losses, damages or expenses which may occur as a result of any act or omission of HSHS's, its members, directors, officers, employees or representatives, or which may arise from the individual's participation in the job shadow program at HSHS's.

**Illness-** The Individual hereby forever releases and shall discharge all claims and causes of action whatsoever, present and future, against HSHS's its directors, officers, colleagues and agents, related to or arising out of any illness, disease or health condition the individual may contract, develop or come into contact with while on the premises of HSHS's.

**Medical Treatment –** HSHS's shall provide or refer outpatient treatment to individuals while in the facility for job shadow program placement in case of an accident or illness. However, in no circumstances shall HSHS's bear the cost of the emergency outpatient treatment.

**Ministry Policy -** The individual agrees to conform to all policies and procedures including those relating to safety, patient care and non-discrimination. These policies and procedures include all standards covered by HSHS's' Code of Conduct, Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) and Occupational Safety and Health Administration (OSHA) requirements.

**Communicable Disease -** The individual agrees to disclose if he/she has had contact with others who have Varicella, Severe Acute Respiratory Syndrome, or other communicable diseases that would threaten the safety of patients or staff.

**I have completed all of the required elements to participate in this experience. I meet the health requirements as outlined in Section I of this agreement, and I have read the "Observers – Job Shadows" policy; specifically the limitations of the observers and the confidentiality requirements and agree to abide by the policy, and all terms of this agreement.**

_____ _____

Observer signature Date Guardian Signature

Date

**(If Observer is under 18 years of age)**

_____

HSHS's Sponsor signature Date

**Leader Approval:**

_____

HSHS Leader/Medical Practice Director/CPO signature Date