HOCKING VALLEY
Community Hospital

SHADOWING EXPERIENCE APPLICATION

Thank you for your interest in applying for a shadowing experience at Hocking Valley Community Hospital. Our dedicated team has a passion for healthcare and loves being involved in the community by assisting with the future of healthcare.

This application is for shadowing students, those observing in an actual workplace to gain exposure to a particular occupation or profession. You must be at least 16 years of age and may only shadow one day/one time (no more than 8 hours). Shadowing is limited to outside patient care areas; observation only. No access to Patient Health Information.

Please take a few minutes to complete the application and return it prior to your anticipated start date. Once your application has been reviewed, you will be notified of the decision regarding your student experience request.

Again, thank you for your interest in applying for a shadowing experience at Hocking Valley Community Hospital!

Please email or send completed student application directly to:

Hocking Valley Community Hospital:

Attention: Nick Kost
P.O. Box 966
601 State Route 664 North
Logan, Ohio 43138

Email: nkost@hvch.org

Phone: (740) 380-8286

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STUDENT APPLICATION

PERSONAL INFORMATION:

Date:

Student Name:

Address: Phone #:

City/State/Zip: Email:

Check here if you are under 18: ☐ Birthdate:

Parent signature needed if under 18

SCHOOL INFORMATION:

School Name: Instructor:

Instructor Email: Phone:

Program of Study: Hours Needed:

Anticipated Graduation Date:

Departments Interested in Shadowing:

Days/Times Available:

In consideration of my unpaid student experience at Hocking Valley Community Hospital, I agree to comply with rules and regulations of the facility. I understand that my unpaid student experience can be terminated at any time and for any reason, at the option of the facility, the school, or myself. I understand this unpaid student experience does not enter me into an agreement of employment with Hocking Valley Community Hospital. I hereby affirm the information provided on this application is true and complete. I understand any false or misleading representations or omissions may disqualify me from this unpaid student experience. I hereby authorize persons and schools named in this application to provide this facility with any relevant information regarding my unpaid student experience, and I release all such persons from any liability regarding the provision or use of such information.

Signature: Date:

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CONFIDENTIALITY STATEMENT

To be signed by each student as a condition of participation in any shadowing/observation/internship/practicum experience

I understand that as a student completing my shadowing/observation/internship/practicum experience at Hocking Valley Community Hospital ("HVCH"), I may be exposed to Confidential Information (as defined below) regarding patients and financial or other business information produced by or held by HVCH. During the term of my experience with HVCH and any related activities, and for any time thereafter, I shall not directly or indirectly, make or cause to be made, any disclosure or release of any Confidential Information to anyone not authorized by HVCH. For purposes of this agreement, the term "Confidential Information" means any patient, business, medical, or financial information not generally known to the public at large regarding patients, employees and physicians of HVCH and the business and operations of HVCH. Any unauthorized disclosure of Confidential Information by me shall constitute grounds for immediate termination from all student experiences at HVCH and may be grounds for legal action against me by the affected parties and possible criminal charges.

Signature: Date:

My typed name above shall have that same force and effect as my written signature. Your signature verifies that you have read and understand the information provided and hereby agree to adhere to the rules and regulations of the facility.

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INFORMED CONSENT AND RELEASE

The purpose of this form is to inform you about risks of working in healthcare.

Working in a healthcare facility is inherently risky, given the patient population may be carrying any number of illnesses that, despite proper precautions, may be passed to staff and visitors. Certain diseases or illnesses can be acquired when you come into contact with any person who is infected. While we have taken every precaution to make HVCH as safe as possible, we cannot guarantee the Hospital is free of infectious diseases or other harms.

Release

By signing below, I release HVCH, its successors, agents, employees, and assigns, from any and all claims, damages, costs, liability and expenses for any exposure to illness that may occur to me during my educational experience at HVCH.

Confirmation of Understanding and Statement of Consent by Student

I have read and understand this Consent and Release and have been able to ask questions about my education experience at HVCH. All my questions and concerns have been addressed. I agree to abide by all policies and procedures of HVCH, including but not limited to following all PPE and infection control (including the handwashing policy) policies.

Signature: Date:

My typed name above shall have that same force and effect as my written signature. Your signature verifies that you have read and understand the information provided and hereby agree to adhere to the rules and regulations of the facility.

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STUDENT SYSTEMS ACCESS SECURITY AGREEMENT

I (name of student) have read, understood, and will comply with the following:

1. I understand that my system access is a function of my official duties and student status:
    a. All access to Information Systems is subject to monitoring and logging.
    b. Accounts can be disabled or revoked at any time – with or without notification – in the interest of network security.
    c. User shall manually lock unattended computers.
    d. Personally owned mobile devices may not be connected to non-public, company owned wired or wireless networks. Mobile devices include, but are not limited to, laptops, smart phones, tablets, USB storage, etc.
    e. All information stored on Hocking Valley Community Hospital is the property of Hocking Valley Community Hospital.

2. I am required to protect my accounts, passwords, system and any information that I access:
    a. All access to Information Systems is tracked and monitored.
    b. User may not share information pertaining to their user ID, passwords, personal identification numbers, etc. and may not ask for use of another person's identification and authentication information.
    c. If user believes their user identification and/or password have been compromised, they must report the incident immediately to Information Service.

3. I agree to utilize workstation precautions.
    a. I will not eat or drink at workstation.
    b. I will not insert any device into HVCH equipment unless instructed by Information Services. This includes USB drives and charging cables, earphones, microphones, CD/DVDs.
    c. Do not access information not needed for your student experience.

I understand that non-compliance may lead to dismissal from my student experience at the Hocking Valley Community Hospital.

Signature: Date:

My typed name above shall have that same force and effect as my written signature. Your signature verifies that you have read and understand the information provided and hereby agree to adhere to the rules and regulations of the facility.

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POST SIGN OUT SHEET

Thank you for job shadowing at Hocking Valley Community Hospital! Please have your shadowing preceptor complete this sign out sheet and return to the Community Relations Department.

WAIVERS SIGNED:

_____ Student Application

_____ Confidentiality Statement

_____ Security Agreement

HOURS COMPLETED: _____

PRECEPTOR NAME: _____

PRECEPTOR DEPARTMENT: _____

PRECEPTOR SIGNATURE: _____