HUTCHINSON
REGIONAL MEDICAL CENTER

JOB SHADOW OBSERVATION AGREEMENT

Please fill out the following information as directed and return to the Education Department at least 48 (business) hours prior to the requested observation time. *(Please print legibly.)*

NAME: _____ DATE OF BIRTH: _____

PHONE: _____ Email: _____

AREA(S) REQUESTED FOR OBSERVATION: _____

DATE(S) REQUESTED FOR OBSERVATION: _____

CONTACT PERSON IN CASE OF EMERGENCY:

NAME: _____ PHONE: _____

RELATIONSHIP: _____

I will adhere to the following stipulations during my observational experience at HRMC:

- ☐ **In accordance with HIPAA regulatory requirements, I will treat all patient information that I see and/or hear as confidential and privileged information. I will not access patient information without an assigned HRMC staff member and will only do so for the purposes of education. I will not disclose any patient information to any other persons or organizations and I will not copy or remove any patient records from the premises. I understand that the penalties for breaches of confidentiality are subject to certain provisions of state and federal law.**
- ☐ I will abide by all of Hutchinson Regional Medical Center's policies, procedures, rules and regulations. I have been provided a copy of the HRMC Key Safety Packet, the Compliance Program packet, and the Code of Conduct packet and have been given the opportunity to ask any questions I may have.
- ☐ I acknowledge that there exists the potential for injury or illness. I am aware that in the event of my injury and/or illness, I and/or my own insurance carrier will pay for any medical care cost incurred. I hereby release Hutchinson Regional Healthcare System of any necessary health expenses incurred by either illness and/or injury during the period of observation.

(continued)

- ☐ I will follow all directives of the personnel to whom I am assigned.
- ☐ I will **not** provide any kind of patient care or treatment.
- ☐ I will **not** interfere with the care/treatment of any patient nor disrupt any department's scheduled activity.
- ☐ I will remain in the designated department during all observational periods unless excused by the supervisor or assigned personnel.
- ☐ I will dress professionally which excludes wearing shorts, halter tops, t-shirts, opened toed shoes, or any clothing with offensive writing or pictures. I understand that I will not be permitted to participate in the job shadow experience if not dressed appropriately.
- ☐ I understand that I will only be allowed to be present for a patient treatment or procedure if the patient gives their consent.
- ☐ I understand that if I'm shadowing during influenza season, I will need to show proof of having the influenza vaccine or will need to wear a mask when in patient care areas and areas where guests and visitors congregate.
- ☐ I understand that Hutchinson Regional Medical Center reserves the right to discontinue my observational experience if I do not comply with any of the above listed stipulations.
- ☐ I am 16 years of age or older and will provide proof of age upon request.

By signing this form, you hereby confirm that you have read and agreed to all of the statements on this form and that your personal information is correct.

Signature: _____ Date: _____

Required if student is under 18 years of age:

Parent/Guardian Signature: _____ Date: _____

Print Name: _____

HRMC Use Only:

Agreement received on: _____

Education Dept. Approval by: _____

Sent to manager(s) of requested unit(s) on: _____