UnityPoint Health
Des Moines

Job Shadowing Application

CONTACT INFORMATION

Full Name (First, Middle Initial, Last):

Home Address:

City, State, Zip:

Phone:

Email:

Date of Birth:

Name of School Currently Attending:

Year in School:

Please provide any special accommodation needs:

Have you ever volunteered or been employed by UnityPoint Health – Des Moines? ☐ Yes ☐ No

you have family members employed at UnityPoint Health – Des Moines? ☐ Yes ☐ No

If yes, please provide full name:

OCCUPATION/CAREER INTEREST

Identify dates and times available for your interview or job shadow request:

PARENTAL CONSENT (REQUIRED IF UNDER AGE 18)

Please provide name and contact information for parent/legal guardian:

Contact name:

Relationship:

Phone:

To be completed by parent/legal guardian:

I _____ (parent/legal guardian name), approve _____ (participant's name) to participate in UnityPoint Health's Job Shadowing Program.

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COMPLETE THE FOLLOWING SECTION FOR ALL IN-PERSON INTERVIEW OR JOB SHADOW REQUESTS

Emergency contact name:

Relationship:

Phone:

Emergency Contact Name:

Relationship:

Phone:

ATTESTATION

The information provided on this application is true and completed to the best of my knowledge. I verify I have received, read and understand the UnityPoint Health – Des Moines Orientation Manual outlining the following policies/procedures:

a. Confidentiality and HIPAA
b. Document Control
c. Internal Reporting Requirements
d. Infection Prevention
e. Personal Protective Equipment
f. Safety
g. Emergency Procedures
h. Professional Appearance

To be completed by the participant:

I _____ (participant's name), verify I have completed the self-guided orientation as stated above.

UnityPoint Health
Des Moines

CONSENT AND RELEASE FORM

In consideration of the opportunity to voluntary participate in a learning program at UnityPoint Health – Des Moines as part of the Job Shadowing Program, I agree to the following:

1. I certify that I am at least fourteen (14) years of age or older.
2. I understand that patients undergoing examination, procedure or treatment must consent to my presence.
3. I agree to maintain and protect the absolute confidentiality of the names of the patients and any other patient identifying information, as well as the information relating to the condition, diagnosis, and treatment of any patient of which they become aware during the course of the job shadow.
4. I understand that this is a job shadow only experience. I agree not to provide care of any kind to any patient or to write on any patient's medical record.
5. I understand that UnityPoint Health – Des Moines will not assume nor provide any type of insurance coverage, including malpractice insurance coverage, for me while I am on hospital premises.
6. I will wear a hospital identification badge at all times while in the hospital identifying me as a voluntary observer. I will conduct myself in a professional manner and surrender the badge to the designated office/person when the experience is completed.
7. I understand that I will, at all times, remain in the presence of the individual whom I am interviewing or observing. I will leave the patient care areas when the interview or job shadow is complete and the hosting individual(s) leave.
8. I acknowledge that no assurance or representation concerning my health or safety during the period of my voluntary interview or job shadow experience has been made to me. I understand that numerous risks to health and safety may be present in a hospital, including but not limited to personal injury or exposure to infectious agents, and I voluntarily assume all risks associated with my presence in the hospital as an observer.
9. I understand that UnityPoint Health – Des Moines reserves the right to terminate the voluntary interview or job shadow experience at any time.

I hereby release UnityPoint Health – Des Moines, its parent, affiliates, and subsidiaries, its medical staff, physicians, directors, officers, employees, agents and representatives from any liability, injury or damages caused by or arising from or in connection with my presence as an observer or participant in the hospital.

By voluntarily signing below, I acknowledge that I have read this Agreement and will comply with all terms and conditions stated.

_____
Student's Name (please print)

_____
Signature of Student

_____
Signature of Parent/Legal guardian if under 18 years old

_____
Individual Being Job Shadowed (please print)

_____
Date of Signature

_____
Date of Signature

_____
Date of Job Shadow