UnityPoint Health
Fort Dodge

Job Shadow Process

Please use the checklist below to complete items that are required for you to complete a job shadow experience.

_____Review Job Shadow policy.

_____Complete and sign Job Shadow Application form.

_____Review and sign Confidentiality Statement of Understanding.

_____Complete and sign waiver. Requires signature of a parent or legal guardian if you are under age 18.

_____Provide documentation of immunizations. Must also have documentation of a recent TB skin test (completed within the last year). Please use the form included with this packet **and** provide documentation to support the information from your physician or student health center.

_____Review orientation packet and sign acknowledgement of completion.

_____Notify Office of Medical Education if there are any physical accommodations we need to be aware of.

_____Return completed forms to:

Trinity Regional Medical Center
(Attn: Office of Medical Education)
802 Kenyon Road
Fort Dodge, IA 50501

Fax number: 515-574-6933
Email: UPH_FtDodge@unitypoint.org

Returned forms should include:

- Job Shadow application
- Confidentiality Statement of Understanding
- Job Shadow Agreement and Waiver
- Health/Immunization record with attachments of record from provider or state immunization registry
- Orientation acknowledgment
- Tuberculosis Screening & Risk Assessment
- COVID-19 Vaccination Declination (if you don't have the COVID-19 vaccine)

The above items must be completed prior to being approved for a job shadow experience. We attempt to accommodate requests, however some requests may be denied.

Upon receipt of these items your request will be reviewed and you will be contacted with information regarding date, time, name of assigned staff member and where to report.

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Job Shadow Application

Personal Information (please print legibly)

First Name _____Last Name_____MI____

Home Address _____

City_____State _____Zip _____

Email_____

Phone Number _____ Cell Phone _____

Are you at least 18 years of age? _____ Yes _____No If no, date of birth _____

If you are under 18 please list name and contact information for parent/legal guardian.

Name_____Phone _____

Are you currently a student?_____Yes_____ No Year in school _____

Name & Address of school _____

What occupation or department do you want to shadow? _____

_____UnityPoint Clinic _____Trinity Regional Medical Center _____Berryhill Center

Name of person you would like to shadow, if known_____

Briefly describe your reason for wanting to job shadow, including your learning and career objectives, number of hours you want to shadow, class/course requirements, etc.

_____
_____
_____
_____

What date(s) and time (s) are you available for your job shadow?

_____

Is this a requirement for a class/course in which you are currently enrolled? ___ Yes __ No

If yes, instructor's name _____Phone _____

Applicant Signature _____ Date _____

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Job Shadow Agreement and Waiver

As a job shadow participant, I agree to and will comply with the above rules for my job shadow experience with UnityPoint Health – Fort Dodge. I will act professionally and in a manner that is a positive reflection of UnityPoint Health – Fort Dodge. I understand that I am to observe only and am not permitted to participate in any aspect of patient care. Additionally, I understand that UnityPoint Health – Fort Dodge, nor any of its employees or officers may be held liable in any way for any injury, illness or other damages to me arising during this job shadowing experience.

Applicant Signature _____ Date _____

Applicant _____ Name of School _____

Home Address: _____

Phone Number: _____Year in school: _____

High School Students:
Teacher/Counselor Recommendation: _____
_____
_____
_____
_____
_____
_____
_____

Teacher/Counselor Name:_____

High School Counselor/Teacher Signature:_____

Date _____

Parental/Guardian Consent for students under the age of 18:
As parent/legal guardian of the above participant, I consent for this individual to participate in a job shadow experience at UnityPoint Health – Fort Dodge and to release UnityPoint Health – Fort Dodge from any claims that may arise from this observation experience.

Parent/Guardian Signature _____ Date _____

Parent Name _____ Phone Number _____

UnityPoint Health
Fort Dodge

Confidentiality Statement of Understanding

I agree to keep patient, clinic and hospital information to myself. I agree that I will not discuss information regarding patients to anyone at the facility or outside the facility unless the communication is necessary to provide care to the patient. Patient and clinic/hospital information is highly confidential and I realize that I could be held liable in a lawsuit for a breach of confidentiality. I understand that there may be patients that I know or recognize, but that I must not disclose that information.

_____
Print Name

_____
Signature

_____
Date

For Human Resources Use

Department_____

Job Shadow Supervisor_____

Job Shadow Date _____

Health/Immunization Record

Provide documentation of completed vaccines and results of testing in addition to completing this section.

Immunizations

Covid19 Vaccine Dates: 1._____ 2. _____

(If you don't have the Covid19 vaccine, please fill out the declination form below.)

Mantoux/TB Test (2-step TB testing) Dates: 1._____ 2. _____

(*Must be within previous 12 months of date of job shadow*)

Measles/Mumps/Rubella (MMR) Dates: 1._____ 2. _____

Tetanus-Diphtheria or Tetanus-Diphtheria-Acellular Pertusus (Tdap) Date: _____

Chicken pox vaccine Dates: 1._____ 2. _____

If you have not had Chicken pox vaccine have you had chicken pox? Yes ___ No___

Influenza Vaccine: Date: _____

Please note: During Influenza season (October-March) documentation of influenza vaccination for the current season will be required. If you are not able to receive the influenza vaccine for a medical reason, please provide documentation from your primary care provider.

Optional:

Hepatitis B Vaccine (series of 3) Dates: 1._____ 2. _____ 3. _____

Known allergies _____

Current infectious disease, chronic health problems or immune disorders

_____

_____

I understand that I may be exposed to contagious diseases, infectious materials, bloodborne pathogens, and other risks associated with the healthcare environment. I will comply with all Infection Prevention policies, but understand that there is still risk involved.

_____ _____

Student Signature Date

Student Name: _____

Parental/Guardian Consent for students under the age of 18:

Parent/Guardian Signature _____ Date _____

Parent Name _____ Phone Number _____

Tuberculosis Screening & Risk Assessment

COMPLETE THIS SECTION:			
Symptom Screening	Do you have any of the following symptoms?		
	1. Persistent, productive cough lasting more than 3 weeks or spitting up any blood?	☐ No	☐ Yes
	2. Night sweats not related to other health problems?	☐ No	☐ Yes
	3. Unexplained/Unplanned weight loss (>10%) in the past 6 months?	☐ No	☐ Yes
	4. Fever for greater than 3 weeks?	☐ No	☐ Yes
Risk Assessment	Are you currently immunocompromised (unable to fight infection) related to meds or illness? *Including human immunodeficiency virus (HIV) infection, organ transplant recipient, treatment with a TNF-alpha antagonist (e.g., infliximab, etanercept, or other), chronic steroids (equivalent of prednisone ≥15 mg/day for ≥1 month) or other immunosuppressive medication	☐ No	☐ Yes
	Have you ever been near anyone with TB?	☐ No	☐ Yes
	Were you born or have you lived in a foreign country? Where: When:	☐ No	☐ Yes
	Have you traveled outside the United States or Canada in the past 12 months? Countries visited in the past 12 months: _____	☐ No	☐ Yes
New Team Members ONLY	Date of last Tuberculosis (TB) test:	Result:	
	If you have had a positive TB test, when was your last chest x-ray?	Result:	
	Have you ever been vaccinated against TB with BCG?	☐ No	☐ Yes
	Have you ever taken medication for TB (ex. INH)?	☐ No	☐ Yes

I certify that the above information is answered correctly to the best of my knowledge, and I am free of any infectious diseases. If I have a communicable disease or feel that I have been exposed to a communicable disease while at UnityPoint Health, I will contact Employee Health.

Signature:_____ **Date:**_____

Employee Health Use Only

Follow Up: ☐ **No Follow Up Needed** ☐ **TB Test** ☐ **Chest X-Ray**	
Employee Health Name:	Date:

Reference:
Nutrition & TB - Malnutrition, under nutrition, assessment. Accessed 9/21/22: Nutrition & TB - Malnutrition, under nutrition, assessment (tbfacts.org)
Health Care Personnel (HCP) Baseline Individual TB Risk Assessment. Accessed 9/21/22: https://www.cdc.gov/tb/topic/infectioncontrol/pdf/healthCareSettings-assessment.pdf
Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from the National Tuberculosis Controllers Association and CDC, 2019. Accessed 9/21/22: https://www.cdc.gov/mmwr/volumes/68/wr/mm6819a3.htm?s_cid=mm6819a3_w

COVID-19 Vaccination Declination

Name (Please Print):_____

Date of Birth:_____ **UPH Region:**_____

Employee ID (if employed by UPH):_____ **UPH Affiliate:**_____

I have been provided the COVID-19 Vaccination Information Sheet (VIS). Employee Health will keep this record of declination in my Employee Health medical file.

Vaccination Declination

□ I have been given the opportunity to be vaccinated with COVID-19 vaccination(s) as recommended by the CDC, at no charge to myself. However, I decline the COVID-19 vaccination(s) at this time. I understand that by declining this vaccine I will be at a higher risk for severe COVID-19-associated illness. If, in the future, I want to be vaccinated with COVID-19 vaccination(s), I can receive the vaccination(s) at no charge to me.

By signing this form, I attest that that the information provided is true and correct.

Signature : _____ **Date:** _____