

Dear Job Shadow/Work Experience Applicants,

The job shadow/work experience program is a beneficial experience that may help you choose a lifetime career. We are dedicated to making your experience at Vernon Memorial Healthcare memorable and rewarding.

There are a few things you must accomplish prior to beginning your job shadow/work experience. This informational packet will highlight our policies and procedures as they relate to patient privacy. It includes information about HIPAA, the Health Insurance Portability and Accountability Act, which is a set of privacy regulations that all health care providers are required to enforce. We, as health care providers, are very concerned about our patient's privacy and security of their health care information. Our goal is to help you learn your role in regard to patient privacy and security.

Please complete all of the forms in this packet and return them to Volunteer Services. Please allow at least two weeks for processing. There are several places for your signature. Signing each of the forms means you understand the information and agree to keep any learned information confidential. The Volunteer Coordinator will be responsible for setting up a job shadow for you.

Please direct any questions to Volunteer Coordinator, Alycia Larson at 608-637-4327 or [alarson@vmh.org](mailto:alarson@vmh.org). Office hours are Monday through Friday 8:00 am - 4:30 p.m.

Sincerely,

Alycia Larson  
Volunteer Coordinator  
507 South Main Street  
Viroqua, WI 54665



## Job Shadow Dress Code

The appearance of job shadow/work experience candidates at Vernon Memorial Healthcare has a direct impact on patients' and customers' perceptions of our professionalism, competency and quality of care. All job shadow/work experience candidates must adhere to general guidelines. Appearance must not be offensive to our patients and staff.

**Nametags** must be worn visibly on the front of outer garments.

**Hair** must be clean and neat.

**Personal Hygiene** is important. Each job shadow/work experience candidate is expected to maintain good grooming habits and hygiene to prevent body odor/bad breath.

**Clothing** must be neat, clean, in good condition and fit properly. Tight clothing, low cut blouses or clothing that allows undergarments to show through may not be worn. Dress/skirt/dress shorts/skorts should be of moderate length. Blue jeans may only be worn for designated "jeans day," or other specified occasions.

**Hose/Socks/Shoes** must be worn at all times and cover any exposed leg area. Closed-toed shoes must be worn when job shadowing staff who are involved in lifting of objects or transfer of patients in any manner (wheelchair, cart, ambulating). Shoes should be kept clean, in good condition, and reflect the needs of the work performed. Business Office Setting: Hose and/or socks are not required with pants, capris or below the knee skirts in this non-patient care setting.

**Accessories:** Earrings, necklaces, rings etc. may be worn in moderation. Safety and patient care should be considered when determining whether jewelry/accessories may be worn. Only jewelry for ear piercings may be visible. Hats will not be worn indoors. No chewing gum is allowed during patient contact.



**Vernon Memorial Healthcare  
Request for Work Experience Program**

(Please Print)

\_\_\_\_\_ Job Shadow-High School      \_\_\_\_\_ Work Experience      \_\_\_\_\_ Other  
\_\_\_\_\_ Job Shadow-College      \_\_\_\_\_ School to Work      Explain: \_\_\_\_\_  
\_\_\_\_\_

Department or Area of Interest:      1<sup>st</sup> Choice \_\_\_\_\_  
2<sup>nd</sup> Choice \_\_\_\_\_  
3<sup>rd</sup> Choice \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street or Fire No.      City      State & Zip

Home Telephone: \_\_\_\_\_ Cell # \_\_\_\_\_ Email Address: \_\_\_\_\_

(If Applicable)      School: \_\_\_\_\_  
Address: \_\_\_\_\_

(If Applicable)      Teacher Contact: \_\_\_\_\_ Phone # \_\_\_\_\_

Emergency Contact: Name: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Home #      Work #      Cell #

Please list any health conditions that we should be aware of:  
\_\_\_\_\_

Expected duration of work experience: \_\_\_\_\_

Times Available: Days: MON TUES WED THURS FRI      From \_\_\_\_\_ To \_\_\_\_\_  
Time of Day

Any other comments: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Applicant Signature      Date

\_\_\_\_\_  
Parental Signature      Date  
\*Required if under age 18

**Requirements:**

- \_\_\_\_\_ 1. A confidentiality statement must be signed
- \_\_\_\_\_ 2. Media waiver form (optional)
- \_\_\_\_\_ 3. Employee Health requirements will be determined by the Employee Health Coordinator
- \_\_\_\_\_ 4. Criminal Background check **(if applicable)**
- \_\_\_\_\_ 5. Internet Usage **(if applicable)**
- \_\_\_\_\_ 6. Must submit a copy of a signed contract with participant/sponsoring organization or a program description **(if applicable)**
- \_\_\_\_\_ 7. Insurance responsibility/liability is clearly stated **(if applicable)**

*Vernon Memorial Healthcare will not be responsible for transportation.  
Vernon Memorial Healthcare reserves the right to terminate this agreement at any time.*

**Return completed forms to Volunteer Services, 507 S. Main Street, Viroqua, WI 54665**

## **Confidentiality Agreement Job Shadow/Work Experience**

Vernon Memorial Healthcare (VMH) has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their health information. Additionally, VMH must assure the confidentiality of its human resources, payroll, fiscal, research, computer systems, and management information. In the course of my employment/assignment/work experience at a VMH organization/practice, I may come into the possession of confidential information. In addition, my personal access code ["USER ID(s) and PASSWORD(s)] used to access computer systems is also an integral aspect of this confidential information.

By signing this document I understand the following:

1. I agree not to disclose or discuss any patient, human resources, payroll, fiscal, research and/or management information with others, including friends or family, who do not have a need-to-know.
2. I agree not to access any information, or utilize equipment, other than what is required to do my job, even if I don't tell anyone else.
3. I agree not to discuss patient, human resources, payroll, fiscal, research or administrative information where others can overhear the conversation, e.g. in hallways, on elevators, in the cafeterias, on public transportation, at restaurants, or at social events. It is not acceptable to discuss clinical information in public areas even if a patient's name is not used. This can raise doubts with patients and visitors about our respect for their privacy.
4. I agree not to make inquiries for other personnel who do not have proper authority.
5. I agree not to willingly inform another person of my computer password or knowingly use another person's computer password instead of my own for any reason.
6. I agree not to make any unauthorized transmissions, inquiries, modifications, or purgings of data in the system. Such unauthorized transmissions include, but are not limited to, removing and/or transferring data from VMH's computer systems to unauthorized locations, e.g. home.
7. I agree to log off prior to leaving any computer or terminal unattended.
8. I agree and have reviewed the privacy handouts.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent if under 18 years old

Please initial the following:

\_\_\_\_\_ I hereby authorize the VMH Marketing Department to photograph/video record me (or my dependent) and use my personal identity (or my dependents). The photos or information obtained through interviews may be used by Vernon Memorial Healthcare or by any other media agencies consistent with the normal practices of the Departments listed above for an unlimited period of time.

