Vernon Memorial Job Shadow & Work Experience Program

Vernon Memorial Healthcare
So much care, so close.

Dear Job Shadow/Work Experience Applicants,

Thank you for your interest in our Job Shadow / Work Experience Program! We look forward to having you on-site at our facility!

The Job Shadow / Work Experience Program is a beneficial experience that will help educate and provide insight to multiple careers within the healthcare setting. Use our Job Shadow / Work Experience Program to gain an in-person perspective on multiple career paths within various healthcare fields. 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 (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 patients' privacy and the 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. Applicants should 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.

Please direct any questions, and return all completed forms, to Kim Sellers, RN at ksellers@vmh.org. Office hours are Monday through Friday 8:00 a.m. - 3:30 p.m. Feel free to also call if you have additional questions: 608-637-4359.

We look forward to seeing you,

Kim Sellers, RN – Health Coordinator

List of Items to Complete or Review:

- ☐ **View the List of Current Available Areas to Shadow**
- ☐ **Complete the Job Shadow / Work Experience Request Form**
- ☐ **Review & Sign Job Shadow / Work Experience TERMS**
- ☐ **Review & Sign Dress Code Policy**
- ☐ **Review & Sign Confidentiality Agreement**
- ☐ **Complete the Health Form**
- ☐ **TB Risk Assessment Form (if no recent TB test)**

Job Shadow Areas

(Subject to Change per Hospital Discretion)

Administration	Imaging (Radiology/X-ray)	Physicians
Anesthesiology	Information Systems (IT)	Physical Therapy
Business Office	Lab	Plant Services
Cardiac Rehab	Laundry	Public Relations and Marketing
Emergency Department	Nursing Dept. (Nurses/CNA)	Purchasing
EMT	Occupational Therapy	Respiratory Therapy
Environmental Services	Patient Accounts/Registration	Speech Therapy
Food and Nutrition Services	Patient and Family Services (Social Work)	Surgery (Nurses, Physicians or Surgery Techs)
Health Education	Pharmacy (Pharmacists) (Hospital and Clinic Pharmacy)	Volunteer Services
HIS (Medical Records)	Pharmacy Techs	Other: Just ask us!
Human Resources	Physician Assistants	

When requesting to job shadow a physician or practitioner, please be specific on what type of specialty you are wanting to shadow. Example: general practice, pediatrics, emergency, surgery, etc.

If requesting to job shadow a nurse, please be specific on what type of specialty you are wanting to shadow. Example: ER nurse, nurse who works with medical/surgical patients, nurse in a clinic, etc.

If you know the name of the person you would like to shadow in a specific department please indicate that on the form as well. All attempts will be made to get you paired up with that person.

The more specific your request is, the better chance at getting an experience that will meet all of your expectations.

We will do our best to accommodate specific requests, but please note that staff availability, patient care, and scheduling will take priority over job shadow / work experience requests.

Vernon Memorial Healthcare
Request for Work Experience Program

Reason For Request:

_____ Job Shadow-High School _____ Job Shadow-College _____ Work Experience _____ School to Work

_____ Other, Please Explain: _____

Department or Area of Interest:

1st Choice: _____

2nd Choice: _____

3rd Choice: _____

Days/Time Available:

Times Available: _____

Days (circle all that apply): M TU W TH F

Your Information (PLEASE PRINT CLEARLY):

Name:_____ Phone Number: _____

Address: _____ Email: _____

Date of Birth: _____ Gender (circle one): MALE FEMALE NON-BINARY OTHER: _____

School you attend (if applicable): _____

School Contact Person (if applicable): _____ Phone Number: _____

Emergency Contact:

Name: _____ Relationship: _____

Primary Phone Number: _____ Backup Phone Number: _____

HEALTH CONDITIONS & VACCINATIONS: Complete the required Health Form attached.

Any other comments or special requests: _____
_____
_____
_____
_____
_____
_____

Job Shadow / Work Experience TERMS:

- Job Shadow applicants must be at least 16 years of age or older.
- Parent signature is required for applicants under the age of 18 years old.
- Vernon Memorial Healthcare will not be responsible for transportation.
- Vernon Memorial Healthcare will not be responsible for lost or stolen items (please only bring necessary items into building).
- Vernon Memorial Healthcare will not provide reimbursement for any cost associated with the job shadow / work experience (gas money, time away from work, clothing, etc.).
- Vernon Memorial Healthcare reserves the right to modify, change, or terminate this agreement at any time.
- Vernon Memorial Healthcare reserves the right to end any job shadow / work experience during the scheduled visit due to any reasons of concern such as safety, behavior, conduct, or breach of terms.
- All packet requirements must be completed and turned in 2 weeks prior to shadow date.
- Job Shadow / Work Experience requests must be approved by Kim Sellers, RN – Health Coordinator and the department manager where visit will be conducted prior to a visit being scheduled.

Return all completed forms to ksellers@vmh.org

I agree to the terms & conditions as required by this application:

_____ _____

Applicant Name (PRINT) Date

_____ _____

Applicant Signature Date

_____ _____

Parental Name (PRINT) **Required if under age 18* Date

_____ _____

Parental Signature **Required if under age 18* Date

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.

Nametag (if applicable) 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. Limit the use of scented / fragrant products.

Clothing must be neat, clean, in good condition with proper fit. Tight clothing, low cut blouses or clothing that allows undergarments to show through may not be worn. Skirts, dresses, shorts/skorts should be of moderate length.

Closed-toed shoes must be worn while job shadowing in any patient care area and for those 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: Sandals may be worn for visits with non-patient care roles.

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. Hats will not be worn indoors. No chewing gum is allowed during patient contact.

*If the job shadow preceptor finds any clothing inappropriate or unprofessional, they reserve the right to cancel or reschedule the job shadow, until appropriate attire is obtained.

I have read and understand the dress code requirements as indicated above:

Date: _____

NAME (PRINT): _____

SIGNATURE: _____

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 job shadow / work experience at Vernon Memorial Healthcare, I may come into the possession of 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 without authorization and supervision, 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 (if applicable).
6. I agree not to make any unauthorized transmissions, inquiries, modifications, or purging 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 (if applicable).

Date: _____

Print Name: _____

Signature: _____

Vernon Memorial Healthcare Job Shadow / Work Experience
HEALTH REQUIREMENTS FORM

Student Name:_____ School:_____

Any Health Conditions? YES / NO If yes, please list:_____

- **The following immunization information are mandatory and must be completed in full.**
- **Copies of immunization records and/or lab results are needed to verify the information listed below: please attach a COPY to this form.**

MMR – Measles, Mumps, Rubella Vaccine: **2 MMR's are required – or dates & results of Titers** Date of vaccine #1:_____, #2:_____ **OR** Measles Titer Date:_____ Result:_____ Mumps Titer Date:_____ Result:_____ Rubella Titer Date:_____ Result:_____	**Chicken Pox (Varicella) Vaccine:** **Vaccine not needed if past history of having chicken pox.** History or disease: YES / NO Date of vaccine #1:_____, #2:_____ **OR** Varicella Titer Date:_____ Result:_____
Hepatitis B Vaccine: **3 Hep B vaccinations are required** **OR a signed declination form.** Date of vaccine #1:_____ #2:_____ #3:_____ **OR** Complete Signed Declination Form: _____	**TB Skin Test:** **Negative TB skin test** **OR complete TB Risk Assessment Form** Date of TB test:_____ Result:_____ _____ Result:_____ **OR** Complete attached TB Risk Assessment Form: _____
Flu Vaccine (November 1 – April 30): **Must have flu vaccination if job shadowing during above months.** Date of Flu Vaccine:_____ **COVID-19 Vaccine - MANDATORY** Brand: _____ Dose 1: _____ Dose 2: _____	

Health requirements and policies apply to all students coming for job shadow / work experience. It is the student's responsibility to submit accurate and timely information.

To the best of my knowledge, the above information is correct, and I do not currently have a communicable disease or health condition that would put the patients/clients/staff or myself at risk.

_____ _____

Student Signature Date

_____ _____

Parent Signature (if student is under 18) Date

Vernon Memorial Healthcare

Name _____
DOB _____
Department _____
Date _____

WISCONSIN TUBERCULOSIS (TB) RISK ASSESSMENT AND SYMPTOM EVALUATION - 2021
ANNUAL UPDATE and Periodic Health Assessment

All of the information on this form shall be kept confidential.

SYMPTOM EVALUATION

Recent TB symptoms: Persistent cough lasting three or more weeks **AND** one or more of the following symptoms:
coughing up blood | fever | night sweats | unexplained weight loss | fatigue

YES ☐ NO ☐

RISK FOR TB INFECTION

Birth, residence, or travel (for ≥ 1 month) in a country with a high TB rate YES ☐ NO ☐

- Includes any country other than the United States, Canada, Australia, New Zealand, or a country in western or northern Europe.
- Travel of extended duration or including likely contact with infectious TB.

Close contact to someone with infectious TB disease YES ☐ NO ☐

RISK FOR PROGRESSION TO TB DISEASE

Human Immunodeficiency virus (HIV) infection YES ☐ NO ☐

Current or planned immunosuppression including receipt of an organ transplant, treatment with an TNF-alpha antagonist (e.g. infliximab, etanercept, or other), chronic steroids (equivalent of prednisone ≥15 mg/day for ≥1 month), or other immunosuppressive medication **in combination with risk for infection from above**

YES ☐ NO ☐

Periodic Work-Related Health Assessment:

Allergies to medicines or food: _____ | **Issues with hearing:** YES ☐ NO ☐

The following health exams have been completed in the last year: PHYSICAL ☐ DENTAL ☐ VISION ☐

Medication side effect that may affect your personal or patient safety: YES ☐ NO ☐

Have you developed any of the following over the last year:
SKIN RASH ☐ DIARRHEA ILLNESS LASTING LONGER THAN 48 HOURS ☐ MUSCULAR / SKELETAL CONCERNS ☐

Are there currently any work-related issues with your health that you would like to discuss with Employee Health?
YES ☐ NO ☐

Employee Health Services only:
- ☐ No risk factors for TB were identified.
- ☐ Risk factors for TB have been identified; further testing is recommended to determine the presence or absence of tuberculosis in a communicable form.