Summit Healthcare

Job Shadow Information

As of September 2024

All Job Shadow experiences are coordinated through the Professional Development Department.

For questions, please contact:

Professional Development Department
928-537-6368

Or email the Clinical Coordination Team at
clinicalcoordination@summithealthcare.net

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General Information

Summit Healthcare has established a Job Shadow program to provide individuals with an interest in pursuing education and/or careers in healthcare, to spend a specified amount of time with a healthcare professional. Most individuals that participate in the Job Shadow program are students, however being a student is not a requirement. The minimum age of an individual requesting a Job Shadow experience is 15 years old. If the requesting individual is under 18 years old, signed parental/guardian permission is required. A maximum of three Job Shadow experiences are allowed, with a maximum time length of 8 hours for each experience; 4 hours if individual is less than 18 years old.

JOB SHADOW EXPERIENCES ARE OBSERVATION ONLY. Participants in a Job Shadow experience cannot participate in any patient care or procedures. Participants are not allowed to enter any patient room or area that has isolation precautions in place (contact, droplet, airborne, special precautions). There is no compensation for Job Shadow experience participants and all Job Shadow experience participants must be with their Job Shadow Preceptor at all times.

All Job Shadow experience requests must be approved by three entities: 1) the Department Director/ Manager or designee in which the Job Shadow experience is being requested 2) the Professional Development Department designee(s) and 3) the person whom the individual will be job shadowing; referred to as the Job Shadow Preceptor. Summit Healthcare takes all precautions to provide individuals with a valuable experience while ensuring and maintaining patient information confidentiality and protection.

Job Shadow experiences may be rescinded at the discretion of the Department Director/Manager in which the Job Shadow experience is to take/is taking place, the Professional Development Department designee(s), or the Job Shadow Preceptor. Job Shadow experiences may be limited during Flu Season; approximately October through April of each year.

The following Departments require special authorization to allow Job Shadow experiences:

- OR (surgery operating room)
- OB (obstetrics) and Nursery
- Emergency Department
- Behavioral Health (not allowed for Shadow experiences)

Job Shadow experience participants must adhere to the following general requirements while shadowing:

- Wear the Summit Healthcare provided ID badge at all times.
- Cannot participate in any patient care or procedures.
- Will not use any personal communication device while shadowing.
- Adhere to the dress code of business casual; no scrubs, lab coats, or other attire that indicates the participant as a healthcare provider.
    - Proper attire will be provided in specialty areas if necessary, e.g. OR scrubs.

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Required Documentation

To meet safety and regulatory requirements, Summit Healthcare requires individuals requesting a Job Shadow experience to provide the following information and documents. This information must be submitted and reviewed prior to confirmation of any Job Shadow experience.

- Completed Job Shadow Experience Application.
- Signed parental or guardian permission (if individual is under 18 years old).
- Demographics: full legal name, date of birth, email address, phone number.
- Preferred dates and times for a Shadow experience.
- Requested department and job role for a Job Shadow experience (if known).
    - If a specific person to Job Shadow is requested, the name and contact of the person is required.
- Signed Workforce Member HIPAA and Confidentiality Agreement.
    - Make sure to view the video via the link within the document.
- Proof of Immunizations.
    - MMR (measles, mumps, rubella) or positive antibody levels
    - History of Varicella or Varivax (chicken pox or Chicken pox vaccine)
    - Tetanus/Tdap
    - HepB (hepatitis B)
- Proof or Declination of COVID vaccination.
- Proof or Declination of Influenza vaccination (required if experiences are Oct—April).
- TB test.
    - PPD skin test within 6 months of date of Shadow experience.
        - This can be completed at Summit Occupational Health for a fee (~$30)
        - Occupational Health Department
            - 4951 S. White Mountain Rd. Bldg A
            - Show Low, AZ 85901
            - 928-537-6949
    - Quantiferon Gold blood test (within 2 years) or Chest X-ray.
    - T-SPOT TB test.

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Job Shadow Permission for an Individual Less than 18 years old

Individual's Name _____

Individual's Address _____

_____

_____

Individual's Date of Birth _____ Individual's Age _____

Emergency Contact Details:

Name _____ Relationship _____

Phone (cell) _____ Phone (other) _____

I give permission for _____
to participate in a Job Shadow experience and for the information to be held and used by Summit Healthcare.
I give permission for medical attention to be sought in case of emergency.

Signature _____ Date _____

Printed Name _____ Relationship _____

Job Shadow Program Application Form

Full Name:

Are you 15 – 17 years of age? ◯ Yes ◯ No Date of Birth:

Home Address:

E-Mail Address:

Contact Phone Number:

School Currently Attending (if applicable):

Very briefly describe your career goals and what you hope to achieve during your shadowing experience:

Please list the job roles and/or areas you would like to shadow:

Please write the name and phone number (if applicable) of any specific person you would like to shadow, and if you have already discussed shadowing with them.

WORKFORCE MEMBER HIPAA AND CONFIDENTIALITY AGREEMENT

Reference Policy: AW1415

By my signature below, I hereby attest and agree as follows:

- I understand that I may have access to patient protected health information (PHI) and confidential information about the business and financial interests, intellectual property, information and documents of Summit Healthcare Association (SHA), collectively referred to as "Confidential Information" in this Agreement. I understand that Confidential Information is protected by both state and federal law, including the Health Insurance Portability and Accountability Act (HIPAA) in every form, including but not limited to, written records and correspondence, oral communications, and computer programs and applications.

- I will comply with all existing and future SHA policies and procedures to protect Confidential Information.

- I will not misuse and I will protect SHA's Confidential Information. I will not acquire, access, use, copy, make notes regarding, remove, release, share, or otherwise disclose Confidential Information, unless permitted by SHA policy. I will not destroy Confidential Information without proper permission or unless permitted by SHA policy.

- I will not share or release any authentication code or device, password, key card, or identification badge (collectively, "credentials") to any other person, and I agree not to use anyone else's credentials. I will log out of all SHA systems at the end of my workday. I will not allow any other person to have access to SHA information systems under my credentials. I will notify the appropriate administrator immediately if I become aware that another person has access to my credentials or otherwise has unauthorized access to SHA information systems or records.

- I will not access my own medical record. I understand I may only access my medical information from the Health Information Management (HIM) Department or my patient portal.

- I will ONLY access patient records on a "Need to Know" basis as required to carry out my job functions. I will not access a patient record, including but not limited to coworkers, friends, family members, etc. unless the access is needed to carry out my job duties. If I encounter a patient who is a friend or family member, I will immediately alert my supervisor to determine if I can hand off to another coworker or colleague. This includes treatment, payment and healthcare operations (TPO).

- I will honor patient privacy and ONLY reveal or discuss health-related information on a "need to know" basis with the healthcare personnel directly involved in the patient's care. This includes, but is not limited to treatment, medical history, current health status, diagnosis, procedures, etc., as it relates to TPO.

- I will not take recordings (photos, video) on SHA premises for personal use. I will comply with all applicable SHA policies and procedures for recordings, including QU1487, AW1522, AW1533, HW1022, MM1002, IT2028 and AW1507PR.

- If I need to debrief and talk about a stressful incident in which I was involved, I will discuss the event only with my director, manager, supervisor or lead, another person as assigned by my director, or the Employee Assistance Program (EAP).

- I agree that my obligations under this Agreement continue after my time as a workforce member (employee, contracted or credentialed provider, volunteer, contractor, student or job shadow) experience ends.

- I understand that in this agreement applies to all workforce members, and if I breach any provision of this Agreement or SHA policies and procedures, SHA has the right to implement disciplinary action or terminate my employment, contract, volunteer status, student access or job shadow experience with or without notice at the discretion of SHA, and that I may be subject to penalties or liabilities under state or federal laws. I agree that, if SHA prevails in any action to enforce this Agreement, SHA will be entitled to collect its expenses, including reasonable attorney's fees and court costs.

Printed Name _____ Employee # if applicable_____

Title or Role_____ Department_____

Signature_____ Date_____

COVID 19 Vaccine Declination Form

I understand that Summit Healthcare Association (SHA) requires that I receive the COVID-19 vaccine to protect myself, patients, staff, and others in our work settings and surrounding community. I have declined to receive the COVID-19 vaccine for medical or religious reasons. I acknowledge that COVID-19 vaccination is recommended by the Centers for Disease Control and Prevention (CDC) for all health care employees to prevent infection from transmission of COVID and its complications, including death, to patients/residents/clients, my co-workers, my family and my community.

I decline the offer of vaccination for the following reason:

☐ I have a medical contraindication to receiving the vaccine:

Healthcare provider Name & signature of validating the medical contraindication (required):

Provider Name: _____ **Date:** _____

Signature: _____

☐ My religious beliefs prohibit vaccination. Please explain:

_____

☐ **Other: Must Explain:**

_____

Employee: _____ **Department:** _____

Signature: _____ **Date:** _____

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Influenza Vaccine Declination Form

I acknowledge that I am aware of the following facts:
Influenza is a serious respiratory disease that kills, on average, 36,000 Americans every year.

- Influenza virus may be shed for up to 48 hours before symptoms begin, allowing transmission to others.
- Up to 30% of people with influenza have no symptoms, allowing transmission to others.
- Influenza virus changes often, making annual vaccination necessary. Immunity following vaccination is strongest for 2 to 6 months.
- I understand that influenza vaccine cannot transmit influenza. It does not, however, prevent all disease.

I have declined to receive the influenza vaccine for medical or religious reasons. I acknowledge that influenza vaccination is recommended by the Centers for Disease Control and Prevention (CDC) for all health care employees to prevent infection from and transmission of influenza and its complications, including death, to patients/residents/clients, my co-workers, my family and my community.

I decline the offer of vaccination for the following reason:

☐ I have a medical contraindication to receiving the vaccine:

Healthcare provider Name & signature of validating the medical contraindication (required):

PROVIDER NAME: _____ Date: _____

Signature: _____

☐ My religious beliefs prohibit vaccination. Please explain:

_____

☐ **OTHER: MUST EXPLAIN**
REASON:

_____

I have read and fully understand the information on this declination form.

Employee: _____ Department: _____
(Print Name)

Signature: _____ Date: _____