PLEASE PRINT ALL INFORMATION

Huron Medical Center

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www.huronmedicalcenter.org

Job Shadow/Observation Application

Applicant Information

Last Name	First Name		Middle Initial
Street Address	City	State	Zip
Phone No. / Email		Date of Birth	Date of Application
Emergency Contact Person	Relationship	Phone No.	

List three occupations you would be interested in job shadowing/observing:

1st Choice _____ 2nd Choice _____ 3rd Choice _____

Do you have a date/time preference of when you would like to shadow/observe:

Month: _____ Day of Week: _____ Time of Day: _____

Briefly explain your goals for this job shadowing/observation experience and how it will benefit you:

_____

_____

_____

Please list any pertinent schooling, extra-curricular activities, and volunteer activities you have been involved in:

_____

_____

_____

Requirements:

- Must be at least 16 years old. Anyone under 18 years of age will require parent/guardian consent.
- Must be free of communicable diseases and satisfy health requirements.
- Must wear identification badge and remain under supervisor of his/her mentor at all times during experience.
- Must provide a valid picture ID (i.e. driver's license, government ID).
- Job shadowing/observation authorization only. No treatment or physical contact with patient/family is allowed.
- Not able to enter any isolation rooms or high risk (i.e. trauma, codes) areas.

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Health Screening
Please answer the following questions:

- In the past three weeks, have you been exposed to anyone with the following (circle all that apply): Measles, Mumps, Varicella (Chicken Pox), Pertussis (Whooping cough), or other communicable disease _____.
- Have you been exposed to someone with tuberculosis in the past three months? Yes or No
- Are you prone to seizures or fainting? Yes or No
  If yes, please describe
  _____
- To the best of my knowledge, I certify that I am in good health and have no preexisting conditions that may have an effect on a patient's health or recovery (i.e. fever, cough, rash, flu) and will notify HMC in the event I develop any of these prior to my scheduled day. _____ **Initial**
- I understand it is recommended that I am up to date on all of the recommended vaccinations based on my age and health history. _____ **Initial**

- I certify that all statements made on this application are true and that I have not knowingly withheld any facts or circumstances which might, if disclosed, affect my application.
- I understand I am not an employee. I hereby release and hold harmless HMC, its employees, and participating facilities from any and all liability arising out of or resulting from my participation in the Job Shadow/Observation Program.
- I certify I have read and understand the Job Shadow/Observation policy.
- I will act in a professional manor and I must abide by the rules and regulations of the facility.
- I understand, if accepted into the program, I will participate ONLY as an observer and, will NOT participate in any hands-on activities involving patients or their families.

_____ Signature of Applicant	_____ Initials	_____ Date

Required if applicant is under the age of 18

I verify the previous information is accurate and I grant my authorization and consent for the above applicant to participate in Huron Medical Centers (HMC) job shadow/observation program and for HMC to administer general first aid treatment for any minor injuries or illnesses experienced by the Minor. If the injury or illness is life threatening or in need of emergency treatment, I authorize treatment or hospital care deemed advisable by the attending medical professionals. I agree to assume financial responsibility for all expenses of such care.

_____ Printed name of Parent/Guardian _____ Signature of Parent/Guardian _____ Contact No.	_____ Initials	_____ Date

Comments:

Return completed application to Human Resources