

Student Experience

Job Shadowing/Observation Request Form

Thank you for your interest observing healthcare professions at Kettering Health Network. We hope that your experience within our facility(s) will help you in determining your educational and career path.

Completion of the Student Experience Request Form does NOT guarantee that you will be able to observe. Departments will make accommodations as patient schedules and staffing permit. Please allow up to two weeks before your planned shadowing date.

Please complete the attached form and submit it to Human Resources with the required documents.

Submit Forms to:

Kettering Medical Center
Attn: Student Observation
3535 Southern Blvd
Kettering, OH 45429



Kettering Health NetworkSM

Kettering Health Network

Shadowing & Observation Request

Section I: Contact Information

Name: _____
(Last) (First) (Middle)

Address: _____
(Street)

(City) (State) (Zip)

Email: _____ Phone Number: _____

Emergency Contact: _____ Phone Number: _____

Emergency Contact: _____ Phone Number: _____

Section II: Education Information

High School _____ Grade _____

College: _____ Graduation Date: _____

Degree/Major(s): _____

Section III: Observation Information *(students can not shadow more than 2 shifts per dept or specialty)*

Department and/or Specialty *(example: Emergency Nurse)* _____

Contact Person (if known) _____

Number of Hours _____ Date(s) *(Please specify)* _____ Shift _____

Reason for Request _____

Section IV: Documentation of Immunizations *(Please attach copy of immunization records)*

	<u>Date</u>
PPD (TB skin test) 2 step within last 12 months	_____
MMR (measles, mumps, rebella) or titer	_____
<i>2 vaccinations after 1st birthday</i>	
History of Chickenpox or vaccination	_____
Hepatitis B vaccinations	_____ or Declination _____

I understand that if I have a known infectious disease, I shall not place myself in areas in which I would jeopardize others in Kettering Health Network. If I become aware that I have or suspect a serious infectious disease, I will notify my instructor or preceptor of KHN Student Experience Coordinator, or Department contact person.

Initial: _____

Section V: Insurance and Liability *(Please attach proof of health insurance)*

Provider Name: _____

Policy Holder Name: _____ Policy Number: _____

I agree to perform only those functions assigned to me by qualified personnel as designate by my department observation facilitator. Additionally, I will not hold Kettering Health Network (KHN) for any contracted illness or personal injuries to me while under this agreement. I will assume financial liability for any emergency or medical care needed in relation to this observational experience.

Initial: _____

Section VI: Confidentiality

As a Student Observer of Kettering Health Network (KHN), I agree to observe the privacy rights of the patients and their medical information as regulated by the Federal Health Insurance Portability and Accountability Act of 1996. This means that any individual medical data or information that I may hear, see, or observe is not to be disclosed to any individual outside the intent and purpose of the recruitment observation visit. The information may be discussed with the people directly involved in conducting the visit. I understand the need for and agree to maintain confidentiality. This means I cannot read the patient's chart, cannot tell others outside the hospital that this person is in the hospital, and can not tell anyone any information about the patient. I further understand that if I do disclose patient specific data and information to any unauthorized individual, I may be liable for severe fines and penalties.

Initial: _____

Section VII: KHN Policy and Behavior

I, the undersigned individual, understand that I am participating in this recruitment observation visit as a volunteer to gain a deeper understanding about careers in the medical field and this visit is a privilege for me. I expect no compensation for this observational experience.

I will conduct my observational activities at Kettering Health Network only under the supervision of the designated Kettering Health Network employee. I will support the philosophy of Kettering Health Network and the department in which the experience is being obtained. .

I agree to support Kettering Health Network's policy of professional appearance. Shorts, jeans, capris, sandals, and open toed shoes are not allowed. Each person must be neat, clean and devoid of strong perfumes or body odors. Make-up and nail polish can be used in neutral or moderate shades. Visible tattoos are to be covered.

I agree to conduct my observational activities in a professional manner. I agree to not smoking and not using illegal drugs or alcohol or foul language anywhere on the premises.

Signature: _____ **Date:** _____

Signature of parent or guardian _____ **Date:** _____
(If visitor is under 18 years)

Printed name of parent or guardian _____