HOCKING VALLEY
Community Hospital

SHADOWING EXPERIENCE APPLICATION

Thank you for your interest in applying for a shadowing experience at Hocking Valley Community Hospital. Our dedicated team has a passion for healthcare and loves being involved in the community by assisting with the future of healthcare.

This application is for shadowing students, those observing in an actual workplace to gain exposure to a particular occupation or profession. You must be at least 16 years of age and may only shadow one day/one time (no more than 8 hours). Shadowing is limited to outside of patient care areas; observation only. No access to Patient Health Information.

ALL APPROVED SHADOWING STUDENTS MUST HAVE PROOF OF FULL COVID-19 VACCINATION.

Please take a few minutes to complete the application and return it prior to your anticipated start date. Once your application has been reviewed, you will be notified of the decision regarding your student experience request.

Again, thank you for your interest in applying for a shadowing experience at Hocking Valley Community Hospital!

Please email or send completed student application directly to:

Hocking Valley Community Hospital:

Attention: Latricia Johnston
601 State Route 664 North
Logan, Ohio 43138

Email: ljohnston@hvch.org

Phone: (740) 380-8336

STUDENT APPLICATION

PERSONAL INFORMATION:

Date:

Student Name:

Address: Phone #:

City/State/Zip: Email:

Check here if you are under 18: Birthdate:

Parent signature needed if under 18

SCHOOL INFORMATION:

School Name: Instructor:

Instructor Email: Phone:

Program of Study:

Anticipated Graduation Date:

In consideration of my unpaid student experience at Hocking Valley Community Hospital, I agree to comply with the rules and regulations of the facility. I understand that my unpaid student experience can be terminated at any time and for any reason, at the option of the facility, the school, or myself. I understand that this unpaid student experience does not enter me into an agreement of employment with Hocking Valley Community Hospital. I hereby affirm that the information provided on this application is true and complete. I understand that any false or misleading representations or omissions may disqualify me from this unpaid student experience. I hereby authorize persons and schools named in this application to provide this facility with any relevant information regarding my unpaid student experience, and I release all such persons from any liability regarding the provision or use of such information.

Signature: Date:

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CONFIDENTIALITY STATEMENT

To be signed by each student as a condition of participation in any shadowing/observation/internship/practicum experience

I understand that as a student completing my shadowing/observation/internship/practicum experience at Hocking Valley Community Hospital ("HVCH"), I may be exposed to Confidential Information (as defined below) regarding patients and financial or other business information produced by or held by HVCH. During the term of my experience with HVCH and any related activities, and for any time thereafter, I shall not directly or indirectly, make or cause to be made, any disclosure or release of any Confidential Information to anyone not authorized by HVCH. For purposes of this agreement, the term "Confidential Information" means any patient, business, medical, or financial information not generally known to the public at large regarding patients, employees and physicians of HVCH and the business and operations of HVCH. Any unauthorized disclosure of Confidential Information by me shall constitute grounds for immediate termination from all student experiences at HVCH and may be grounds for legal action against me by the affected parties and possible criminal charges.

Signature: Date:

My typed name above shall have that same force and effect as my written signature. Your signature verifies that you have read and understand the information provided and hereby agree to adhere to the rules and regulations of the facility.

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Informed Consent and Release Regarding Coronavirus (COVID-19)

The purpose of this form is to inform you about the risks regarding the Coronavirus and your education experience at Hocking Valley Community Hospital ("HVCH").

What is Coronavirus? Coronavirus, or COVID-19, is a respiratory illness caused by a novel (new) coronavirus that can spread from person to person. To protect yourself, you should follow the same steps that help to prevent other illnesses, like the flu. The virus is thought to spread mainly between people who are in close contact with one another (within about 6 feet) through respiratory droplets produced when an infected person coughs or sneezes.

What have we done to protect you from Coronavirus? The health and safety of our patients and staff is our top priority. We have taken additional steps to help protect everyone at the Hospital:

1. All of our personnel utilize appropriate personal protective equipment ("PPE") and follow current guidelines regarding infection control.
2. We have limited visitors and other people from accessing the hospital and physician offices to limit the spread of the disease.
3. In addition to our normal, very thorough cleaning and disinfecting procedures, we have implemented cleaning procedures specifically directed at the Coronavirus.
4. We perform daily health checks on all of our staff. Any staff member who shows any signs or symptoms of Coronavirus is not permitted to work.
5. We have followed all Federal, State, and Local guidelines given during the current Coronavirus pandemic.

Risks associated with the Coronavirus: The Coronavirus can be acquired when you come into contact with any person who is infected. One of the problems with this disease is that many people who are infected do not show any signs or symptoms (asymptomatic). Therefore, you may be exposed any time you interact with another person, whether at the local store, gas station, your workplace, or at the hospital. While we have taken every precaution to make HVCH as safe as possible, we cannot guarantee that the Hospital is free of Coronavirus or asymptomatic individuals. Simply put, you may contract Coronavirus anywhere other individuals are, including HVCH.

Individuals at Higher Risk: People are more at risk for Coronavirus if they live in or have recently traveled to places where ongoing community spread of the virus has been reported, OR if they have been in close contact with someone diagnosed with Coronavirus. In addition, some people are at higher risk for serious illness from Coronavirus, including:

1. People who are 60 and older.
2. People with underlying health conditions, including heart disease, lung disease, or diabetes.
3. People with weakened immune systems.
4. People who are pregnant.

If you fall into one of these categories, please make sure you discuss this situation with your HVCH supervisor prior to your rotation.

Release

By signing below, I release HVCH, its successors, agents, employees, and assigns, from any and all claims, damages, costs, liability and expenses for any exposure to the Coronavirus that may occur to me during my educational experience at HVCH.

Confirmation of Understanding and Statement of Consent by Student

I have read and understand this Consent and Release and have been able to ask questions about my education experience at HVCH. All of my questions and concerns have been addressed. I agree to abide by all policies and procedures of HVCH, including but not limited to:

1. I will follow all PPE and infection control (including the handwashing policy) policies;
2. I will immediately report to my HVCH supervisor if I experience any signs or symptoms of Coronavirus;
3. I will undergo a health screen prior to the start of any shift at HVCH;
4. I will immediately inform my HVCH supervisor if I have been exposed to any person known to have Coronavirus, whether at the Hospital or elsewhere.

Signature: Date:

My typed name above shall have that same force and effect as my written signature. Your signature verifies that you have read and understand the information provided and hereby agree to adhere to the rules and regulations of the facility.

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STUDENT SYSTEMS ACCESS SECURITY AGREEMENT

I (name of student) have read, understood, and will comply with the following:

1. I understand that my system access is a function of my official duties and student status:
    a. All access to Information Systems is subject to monitoring and logging.
    b. Accounts can be disabled or revoked at any time – with or without notification – in the interest of network security.
    c. User shall manually lock unattended computers.
    d. Personally owned mobile devices may not be connected to non-public, company owned wired or wireless networks. Mobile devices include, but are not limited to, laptops, smart phones, tablets, USB storage, etc.
    e. All information stored on Hocking Valley Community Hospital is the property of Hocking Valley Community Hospital.

2. I am required to protect my accounts, passwords, system and any information that I access:
    a. All access to Information Systems is tracked and monitored.
    b. User may not share information pertaining to their user ID, passwords, personal identification numbers, etc. and may not ask for use of another person's identification and authentication information.
    c. If user believes that their user identification and/or password have been compromised, they must report the incident immediately to Information Service.

3. I agree to utilize workstation precautions.
    a. I will not eat or drink at workstation.
    b. I will not insert any device into HVCH equipment unless instructed by Information Services. This includes USB drives and charging cables, earphones, microphones, CD/DVDs.
    c. Do not access information not needed for your student experience.

I understand that non-compliance may lead to dismissal from my student experience at the Hocking Valley Community Hospital.

Signature: Date:

My typed name above shall have that same force and effect as my written signature. Your signature verifies that you have read and understand the information provided and hereby agree to adhere to the rules and regulations of the facility.

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POST SIGN OUT SHEET

Thank you for job shadowing at Hocking Valley Community Hospital!

WAIVERS SIGNED:

Student Application

Confidentiality Statement

COVID Release

Security Agreement

HOURS COMPLETED: _____

PRECEPTOR NAME: _____

PRECEPTOR DEPARTMENT: _____

PRECEPTOR SIGNATURE: _____