Fremont Health

Northern Nebraska AHEC Area Health Education Center

STUDENT INFORMATION SHEET

NAME: _____ **DOB:** _____ **Age:**_____

HOME ADDRESS: _____**CITY, ZIP:**_____

MOBILE PHONE: _____ **HOME PHONE:** _____

HIGH SCHOOL or COLLEGE:_____ **Year in School or Grade** _____

INSTRUCTOR/
COUNSELOR/ADVISOR:_____ **School to Career Student? Yes/No**

EMAIL ADDRESS: _____
SOCIAL MEDIA: (check all that you use): Facebook__ Instagram__ Twitter__ LinkedIn__

RACE: (Check One) Caucasian__ African American__ Native American__ Pacific Islander___ Asian__ Other__ Prefer to not answer___ **GENDER:** Female__ Male__ **ETHNICITY**: Hispanic Yes ____ No_____

AREAS YOU WISH TO SEE (Number 1-3 in order of preference) at hospital or community sites

___Athletic Trainer	___Medical Laboratory	___Podiatry (feet)
___Business Office	___Medical Office Assistant	___Physical Therapy
___Ophthalmology, Optometry (eyes)	___Nursing-hospital	___Physical Therapy Assist.
___Dentist	___Nursing- Long Term Care	___Physician: Specialty_____
___Dental Hygiene		
___Dental Assistant	___Nutrition (Dietetics)	___Physician Assistant
___Hospital Administration	___Chiropractic	___Radiology
___Hospital Ministry	___Occupational Therapy	___Recreational Therapy
___Social Services	___Pharmacy	___Respiratory Therapy

WHY DO YOU WISH TO SHADOW IN THESE AREAS?

_____

_____

DATE YOU WISH TO SHADOW (Please list 3 dates at least two weeks from now in order of preference)
1. _____ 2. _____ 3. _____
Number of shadowing hours desired: _____

EMERGENCY NOTIFICATION:
NAME: _____ PHONE: _____

Return the following completed forms: Student Information Sheet, Dress Code, Release of Liability, Confidentiality and Health Assessment forms to:
Northern Nebraska AHEC, 110 North 16th St, Ste #2, Norfolk, NE 68701 Fax: 402-644-7254
Go to www.nnahec.org under Job Shadowing, "Looking for Confidentiality & HIPAA Training" for quiz.
I submitted my test on this date ___/___/___.

Fremont Health

Northern Nebraska AHEC Area Health Education Center

110 North 16th St, **Suite #2**
Norfolk, NE 68701
(402) 644-7253

AFFIRMATION AND RELEASE OF LIABILITY

(Student UNDER 19 years of age) (19+ on second page)

I, _____, the parent of legal guardian of _____, a minor child, hereby acknowledge that I am cognizant of and understand that there are inherent dangers in my child participating in the Fremont Health and Northern Nebraska AHEC Student Shadow Program, which includes, but is not limited to encountering experiences which may be relatively new and may be taxing on my child's senses and also being around an environment that has sick and injured patients.

In consideration of my child being allowed to participate in this program, I hereby assume all risk in connection with any of the above mentioned activities, situations and being present at any of the facilities of Fremont Health or Northern Nebraska AHEC. I hereby give permission for my child to participate in the Fremont Health and Northern Nebraska AHEC Student Shadow Program and I hereby release Fremont Health and Northern Nebraska AHEC, its administration, board of directors, employees, and agents from any and all liability related to my child's participation in the Fremont Health and Northern Nebraska AHEC Shadow Program.

I further state that I am the parent or legal guardian of my child, I am of lawful age, and I am competent to sign this Affirmation and Release of Liability form; that I understand the terms herein are contractual, and not a mere recital; and that I have signed this document as my own free act. I am fully informed of the contents of this Affirmation and Release of Liability, as I have read it before I have signed it.

_____ _____

Signature of Parent of Legal Guardian Date

Fremont Health

Northern Nebraska AHEC Area Health Education Center

110 North 16th St, **Suite #2**
Norfolk, NE 68701
(402) 644-7253

AFFIRMATION AND RELEASE OF LIABILITY

(Student 19 years of age or OLDER)

I, _____, hereby acknowledge that I am cognizant of and understand that there are inherent dangers in my participating in the Fremont Health and Northern Nebraska AHEC Student Shadow Program, which includes, but is not limited to encountering experiences which may be relatively new and may be taxing on my senses and also being around an environment that has sick and injured patients.

In consideration of my being allowed to participate in this program, I hereby assume all risk in connection with any of the above mentioned activities, situations and being present at any of the facilities of Fremont Health or Northern Nebraska AHEC. I hereby release Fremont Health and Northern Nebraska AHEC, its administration, board of directors, employees, and agents from any and all liability related to my participation in the Fremont Health and Northern Nebraska AHEC Shadow Program.

I further state that I am at least nineteen (19) years of age and I am competent to sign this Affirmation and Release of Liability form; that I understand the terms herein are contractual, and not a mere recital; and that I have signed this document as my own free act. I am fully informed of the contents of this Affirmation and Release of Liability, as I have read it before I have signed it.

_____ _____

Student Signature Date

Fremont Health

Northern Nebraska AHEC Area Health Education Center

NORTHERN NEBRASKA AHEC
110 North 16th Street, Suite #2
Norfolk, NE 68701
(402) 644-7253 FAX (402) 644-7254

NORTHERN NEBRASKA AHEC SHADOWING DRESS CODE

The following dress code will be strictly enforced. If you have any questions regarding this code, please contact NNAHEC before signing.

- We ask that the student dress in a manner that presents a look of professionalism.
- Participants must dress modestly and neatly with shirt tucked into pants.
- Please avoid extreme dress, hairstyles and jewelry.
- Do not wear clothing that portrays suggestive or derogatory pictures and messages, including advertising of alcohol, tobacco, etc.
- Clothing should cover all undergarments.
- No sleeveless blouses, shirts or tops.
- Clothing should not be skin tight or revealing.
- The wearing of nose, eyebrow, tongue, lip and body jewelry is prohibited during shadowing hours.
- Body tattoos must be covered during shadowing hours.
- Wear flat comfortable walking shoes – no sandals or open-toed shoes.
- Wear dress slacks – NO BLUE JEANS please.
- Students shadowing Physical Therapy or Occupational Therapy are asked to wear polo shirts and dress slacks.
- Nursing students are required to wear tennis shoes and socks.

The Shadowing Director is responsible to evaluate the dress and appearance of all students. If a student is not dressed appropriately, the student's parents will be contacted to bring appropriate attire or remove the student from the program.

I understand and agree to abide by the Northern Nebraska AHEC Shadowing Dress Code.

Student Signature_____Date _____

(If under 19 years of age)
Parent Signature _____Date _____

Fremont Health

Confidentiality, Security & Information Services
Job Shadow Agreement

As student at Fremont Health, and as a condition of my **job shadowing** experience, I agree to the following:

Confidentiality

1. I understand that I am responsible for complying with the HIPAA policies, which were provided to me.

2. I will treat all information received in the course of my shadowing experience, which relates to the patients, as confidential and privileged information. I understand that Fremont Health has a zero tolerance level for breaches in confidentiality and that Fremont Health will discipline as appropriate including the termination of my job shadow experience.

3. I will not access patient information unless I have a need to know this information in order to perform my role.

4. I will not disclose information regarding Fremont Health patients to any person or entity, other than as necessary to perform my role, and as permitted under the HIPAA policies.

Computer Access and Security

5. I will not log on to the computer systems that currently exist or may exist in the future.

6. I will not take patient information from the premises of Fremont Health in paper or electronic form without first receiving permission from the Privacy officer.

7. I will not bring unauthorized software and load it on a Fremont Health computer.

8. I understand that the IT department will approve software purchased for use at Fremont Health and IT will be responsible for the installation and registration of all software.

9. Upon cessation of my job shadowing experience with the provider, I agree to continue to maintain the confidentiality of any information I learn while at Fremont Health and agree to turn over any keys, access cards, or any other device that would provide access to Fremont Health or its information.

_____ _____

Student Signature Date

Fremont Health

Job Shadow Experience

Health Assessment Screen

Print Student Name	Print Name of School

Check (√) that all three items have been reviewed.
Student and School Nurse must sign form.

☐ **Current and up to date on all Immunizations -** All required immunizations have been administered prior to my Job Shadow experience at Fremont Health.

☐ Student will be **free of communicable diseases** when observing at Fremont Health.

Example: elevated temperature, eye infection (conjunctivitis and pink eye), diarrhea, strep throat, Hepatitis A (jaundice), Measles, Mumps Whooping Cough (Pertussis), Rubella, Scabies, skin lesions that are open and draining, Chicken Pox, Tuberculosis (night sweats, weight loss, fatigue, loss of appetite, coughing up blood).

The student will report such signs and symptoms to Fremont Health's Talent Development Manager (402-727-3746) should they develop while onsite at Fremont Health.

☐ If the participant develops a communicable disease within seven (7) days after observing at Fremont Health, the individual shall report the situation to the Talent Development Manager at Fremont Health.

☐ When returning this form, provide proof of influenza vaccination. (For shadowing dates between Nov. 1 and April 30).

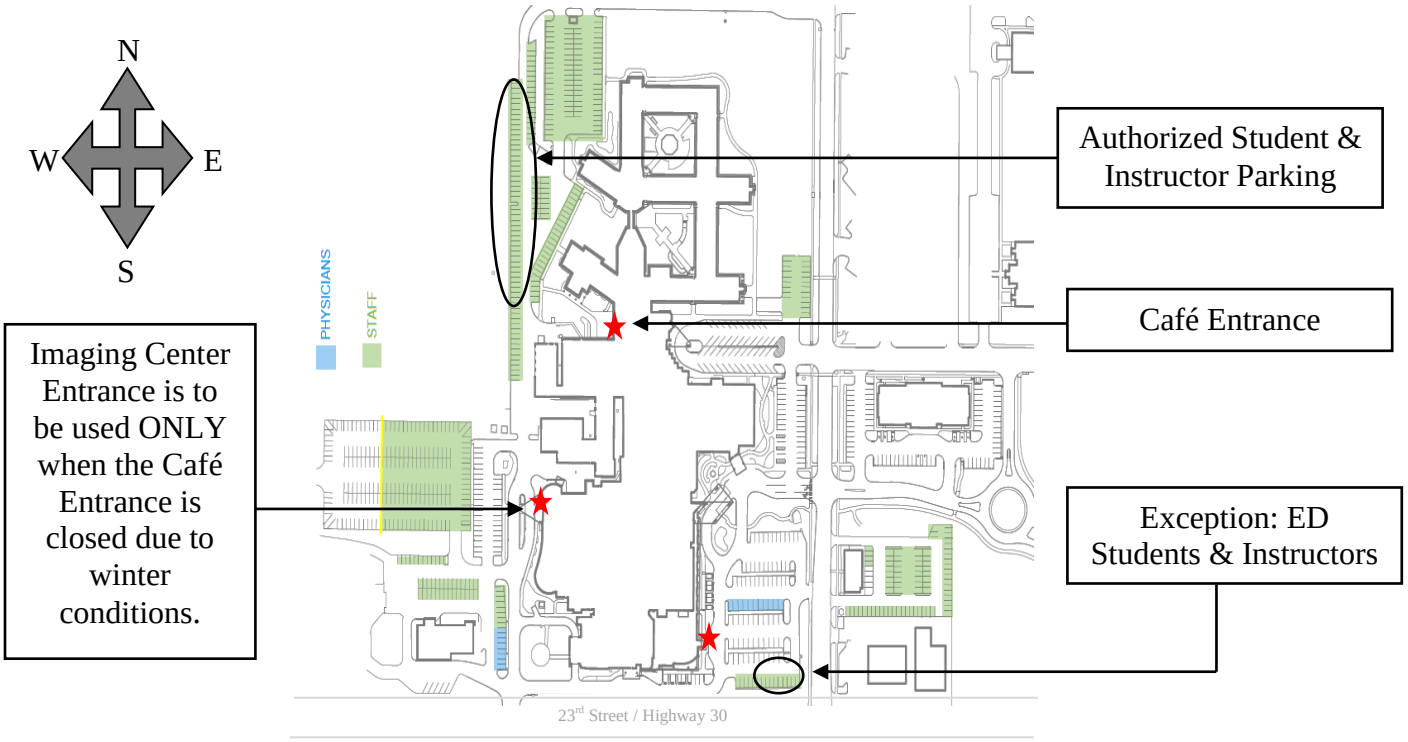
Student Signature: _____ Date: _____

School Nurse: _____ Date: _____

Fremont Health

ACKNOWLEDGMENT OF STUDENT / INSTRUCTOR PARKING & FACILITY ENTRANCES

As a student in an internship program at Fremont Health, I understand that it is my responsibility to park in designated student areas. I understand that as a future patient care provider it is my responsibility to take care of my patients' needs first and that my patients' ability to access our services is vitally important to the patients' wellbeing and my organization's overall customer service philosophy.



Entry through Dunklau Gardens is strictly prohibited. This allows our residents to maintain a sense of home and security while reducing external temperature effects on our residents. Entry through the main Imaging Center doors is also prohibited. Our patients in this waiting room deserve the right to privacy with the least amount of disruptions, disturbances and temperature fluctuations. You may enter the building through the Café (unless marked during winter months). When the Café entrance is closed due to winter conditions, you may enter through the Imaging Center Entrance.

Exception: ED Students & Instructors may park in the Staff Parking area outside of the Outpatient Entrance.

We also ask our students to enter the facility with a sense of professionalism. Although you are completing some of your education on our campus we are a healthcare facility treating patients, holding meetings or hosting events. Your cooperation in maintaining a quiet, clean and professional organization is imperative.

By signing below I acknowledge that I understand these terms and conditions of parking, entry and professionalism. **I fully understand that if I park in undesignated areas my vehicle will be towed at my own expense.**

Name (print): _____

Signature: _____ Date: _____

Vehicle Make/Model _____ License #_____ Year_____ Color_____

Don’t forget to review the Student Self Study Packet. This is a long document so feel free to read online: http://www.nnahec.org/_storage/pagefiles/fremont_study.pdf

Student Name: _____ School Name: _____

FREMONT HEALTH STUDENT ORIENTATION SIGNATURE PAGE

I received information that explained the below items to me and I was provided the opportunity to ask questions.

- Mission
- Vision
- Values
- Corporate Compliance including:
    - Health Insurance Portability and Accountability Act (HIPAA)
    - Confidentiality, Security & Information Services Agreement
    - Protected Health Information
    - Standards of Conduct
- Communication and Teamwork (Handoff Communication)
- Safety (Environment of Care, Security, Utility/System Failure, Fire Safety, Lockout/Tagout, Disaster)
- Health Insurance Portability & Accountability (HIPAA) Confidentiality/Privacy
- Corporate Compliance
- Infection Control
- Influenza / Tuberculosis
- Abuse
- MSDS
- Age Specific Training
- Blood Borne Pathogens
- Back Safety
- Parking (North/West Dunklau Garden Lot)
- Patient Rights & Confidentiality
- Emergency Preparedness and Codes
- Safety Event Reporting
- National Patient Safety Goals
- Student Smoking Policy
- Student Professionalism
- Organization Chart
- Patient Safety and Medical/Health Care
- Error Reduction
- Process Improvement
- IT Security
- Emergency Management
- Transmission Precautions
- Workplace Violence / Sexual Harassment
- Patient's Right
- Population Specific Care and Communication for Diverse Populations

Parking is allowed at the North/West parking lot and entry to should be through the Imaging Entrance. Exception: ED Students may park in the Staff Parking area outside of the radiology entrance. Parking in unauthorized parking areas may result in having your vehicle towed and/or the removal of parking privileges on campus.

Student ID Badges are required at ALL times. Students without their badge will be sent home. Badge replacement cost is $5

I agree to abide by the rules, regulations and policies of Fremont Health. I further understand confidentiality must be maintained concerning patient records. I understand that if I do not abide by the Medical Center's rules, regulations and policies including breach of confidentiality, I will be subject to immediate termination from contractual agreement with Fremont Health indefinitely.

The undersigned agrees that as a condition to participating in the clinical education program at Fremont Area Medical Center, he/she shall:

1. Participate in training covering Fremont Health's policies applicable to students, trainees, and supervising faculty.
2. Access, use, and disclose protected health information of Fremont Health only as permitted under Fremont Health's HIPAA Compliance Program.
3. Be governed as a member of Fremont Health's workforce for HIPAA purposes; and
4. Be subject to sanction, including exclusion from using Fremont Health's facilities or prohibition against accessing Fremont Health's protected health information (PHI), upon violation

Signature: _____ Date: _____

Emergency Contact Information

Your Address: _____
Your Cell Phone # _____
Your E-mail _____

Emergency Contact Name: _____
Relationship to you _____
Contact's Home/Cell Phone # _____
Contact's Work Phone# _____