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

STUDENT INFORMATION SHEET

Please Print

NAME: ____ **DOB:** __________________ **AGE**_________

HOME ADDRESS: ____________________**CITY:**______________ **ZIP CODE:** _______**COUNTY** _____________

HOME PHONE: ______________ **E-MAIL ADDRESS:**____________________ **Graduation Year (HS)**_____________

SCHOOL OR COLLEGE:______________________ **INSTRUCTOR/ COUNSELOR/ADVISOR:**____________________

RACE: (Check One) Caucasian__, African American__, Native American__, Hispanic__, Asian__, Other__, More than 1 Race __, Prefer not to answer___ **GENDER:** Female__, Male__

AREAS YOU WISH TO SEE (List your preference and if more than 1 field of interest, rank number 1-3 in order of preference at hospital or community sites.)

___Athletic Trainer
___Anesthesia –MD, CRNA
___Audiology
___Business Office
___Cardiac Rehab
___Chiropractic
___Counseling
___Dentist
___Dental Assistant
___Dental Hygiene
___Dietetics (Nutrition)
___*EMT/Paramedic*
___Healthcare Administration
___Medical Laboratory
___Medical Office Assistant
___*Nurse Practitioner*
___Nursing-Hospital on 2nd Tues
___Nursing-Other Sites
___Nursing- Long Term Care
___Occupational Therapy
___Ophthalmology (eyes)
___Optometry
___Pharmacy
___Physical Therapy
___Physical Therapy Assist
___*Physician Assistant*
___Podiatry (feet)
___*Radiology*
___Recreational Therapy
___Respiratory Therapy
___Social Services
___*Spanish Translator*
___Spiritual Care
___Veterinary
___Physician Specialty (List below)

____

***Cannot guarantee Specialty

**If you do not see your field listed, please contact us.
Italicized areas are very limited availability.

WHY DO YOU WISH TO SHADOW IN THESE AREAS?

____

____

DATE YOU WISH TO SHADOW If unsure of possible shadowing dates, leave blank and contact us later with definite dates (Please list 3 dates at least two weeks from now in order of preference) If only specific hours work on these days, please note it here.**Some sites may require more than two weeks notice.

1. ____________________ 2. ____________________ 3. ____________________

Number of shadowing hours desired: _____________

EMERGENCY NOTIFICATION: NAME: _________________________ PHONE: ______________

Return the following printed completed forms:
Student Information Sheet, Dress Code, Release of Liability (age appropriate), Understanding of Hospital Confidentiality to:

Northern Nebraska AHEC, 110 North 16th St, Ste #2, Norfolk, NE 68701

Go to www.nnahec.org under Job Shadowing, "Looking for Confidentiality & HIPAA Training" for quiz.
Test is Required Annually
I submitted my test on this date ___/___/__

Revised 9/07

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NORTHERN NEBRASKA AHEC SHADOWING DRESS CODE

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

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 such s T-shirts 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.
- No bare skin showing when bending over or stretching.
- 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.

Shadowing Specific Areas

- If shadowing as an EMT at the Norfolk Fire Department, a collared shirt is required, plus a separate release of liability from the City of Norfolk.
- 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 _____________

1500 Koenigstein
Norfolk, NE 68701
(402) 644-7347

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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 Faith Regional Health Services 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 Faith Regional Health Services or Northern Nebraska AHEC. I hereby give permission for my child to participate in the Faith Regional Health Services and Northern Nebraska AHEC Student Shadow Program and I hereby release Faith Regional Health Services 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 Faith Regional Health Services 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

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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 Faith Regional Health Services 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 Faith Regional Health Services or Northern Nebraska AHEC. I hereby release Faith Regional Health Services and Northern Nebraska AHEC, its administration, board of directors, employees, and agents from any and all liability related to my participation in the Faith Regional Health Services 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

Understanding of Hospital Confidentiality

(Required by Nebraska and U.S. Federal Law and Faith Regional Health Services Policy)
As an employee or associate (i.e. volunteer, student shadow, officer, intern, contract) of Faith Regional Health Services, I, the undersigned, hereby acknowledge that I have read and understand the Faith Regional Health Services' policy on confidentiality of personal health information as described in the Confidential Information Policy, which is in accordance with Nebraska and Federal law.
I also acknowledge that I am aware of and understand Faith Regional Health Services' policies regarding the security of personal health information including the policies relating to the use, collection, disclosure, storage and destruction of personal health information.

I understand that I have the responsibility for maintaining strict confidentiality of information shared with me or acquired by me as a part of my routine duties and access at Faith Regional Health Services. Any patient information, computer passwords, confidential information about an employee, physician, or management and any and all financial information regarding Faith Regional Health Services that is made available to me as an associate or employee of Faith Regional Health Services is for my professional and authorized use only. I understand that such information may be discussed only as needed to perform the duties and responsibilities of my position.

In consideration of my employment/association with Faith Regional Health Services, and as an integral part of the terms and conditions of my employment/association, I hereby agree, pledge and undertake that I will not, at any time during my employment/association with Faith Regional Health Services, or at any time after my employment/association ends, access or use personal health information, or reveal or disclose to any persons or entities within or outside of Faith Regional Health Services, any personal health information except as may be required in the course of my duties and responsibilities and in accordance with all applicable legislation, corporate and departmental laws, rules, regulations or policies governing the release of information.

I understand that my obligations outlined above will continue after my employment/association with Faith Regional Health Services ends and, **I further understand** that my obligations concerning the protection of the confidentiality of personal health information relate to all personal health information, that I have acquired through my employment/association with Faith Regional Health Services or within any of the healthcare facilities owned or managed by Faith Regional Health Services.

I also understand that unauthorized use or disclosure of confidential information will result in corrective action up to and including, but not limited to termination of employment with Faith Regional Health Services, the imposition of sanctions or fines pursuant to Nebraska and Federal laws, and a report to any and all of my professional regulatory bodies.

_______________________________ ____________________

Signature Date

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STUDENT SHADOW PROGRAM POLICIES
GENERAL

The following policies and procedures have been established for Northern Nebraska AHEC Shadow Program.

AGE LIMITS

In order for a student to participate in the Student Shadow Program, he or she must currently be enrolled at least as a Junior or Senior in High School and no less than sixteen (16) years of age. This age requirement is partially due to state health laws concerning hospital visitors. There is a limited shadowing areas for freshmen and sophomores. Please contact us for more details. College students and career seekers are certainly welcomed to shadow.

STUDENT INFORMATION SHEET

Each student wishing to participate in the shadow program will be asked to fill out and return by mail a student information sheet. This sheet will allow our coordinator to more accurately schedule the student.

SHADOW AREAS

A student may list up to three (3) areas in which they wish to shadow on the student information sheet. If more than one field of interest to shadow, please rank number 1-3 in order of preference. We will make our best effort to place the student in their preferred occupation if possible, but first choices may not always be available.

SHADOWING DATES

Please list 3 dates in order of preference that are at least 2 weeks from the time of request. When filling a shadowing request, sometimes there are many people involved in processing the request. Therefore it is very important when writing dates down that you are sure of definite dates that will work. If you do not have your activity or work schedule yet, leave the dates blank. Once you know definite dates that will work, contact NNAHEC. If you have specific time restrictions on a particular day, please note. The more information you provide, the easier the process will be.

RECOMMENDATIONS FOR STUDENTS

- Students need to adhere to the Northern Nebraska AHEC Shadowing Dress Code that he or she signed in the application set.

- Some sites may have additional forms to their particular site for you to sign on your shadowing day.
- Students need to provide their own transportation to their designated shadowing site.
- Inappropriate behavior will not be allowed.
- Personal valuables should be left outside of facility.
- Cell phones, pagers, and beepers will not be allowed.
- If unable to shadow on shadowing date, please call in as a no show with no phone call limits future shadowing.

CONFIDENTIALITY

Due to the nature of the new HIPAA (Health Insurance Portability & Accountability Act of 1996) regulations, confidentiality is a must! All students must complete and pass the Confidentiality Quiz online at www.nnahec.org one week before shadowing date to be eligible for the shadowing program. The HIPAA test must be taken yearly.

REQUIRED FORMS TO BE RETURNED:

- ✓ **THE STUDENT INFORMATION SHEET**
- ✓ **DRESS CODE**
- ✓ **AFFIRMATION & RELEASE OF LIABILITY**
- ✓ **UNDERSTANDING OF HOSPITAL CONFIDENTIALITY**

TO:

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Email: mjanke@nnahec.org

TEST TO BE SUBMITTED ONLINE AT www.nnahec.org

On the left hand menu, click on Job Shadowing for the forms, Confidentiality & HIPAA Training