METHODIST FREMONT HEALTH

Northern Nebraska Area Health Education Center

# Student Information Sheet

**Name:** _____ **DOB:** _____**Age:**_____

**Home Address:** _____ **City, Zip**:_____

**High School or College:** _____ **Year in School or Grade:** _____

**Instructor/Advisor:** _____ **School to Career Student?** Yes/No

**Email Address:** _____

**Mobile Phone:** _____ **Home Phone:** _____

☐ Check the box, if you want to receive information sent via text to your phone about shadowing!

**Race:** (Check all that apply) ____ White/Caucasian ____ Black/African American ____ Asian
____ Native Hawaiian/Pacific Islander _____ American Indian/Alaska Native _____ More than One Race

**Gender:** _____ Female _____ Male **Ethnicity: Hispanic** _____ Yes _____ No

**Areas you wish to see:** (Number 1-3 in order of preference)

| | | |
|---|---|---|
| ____ Athletic Trainer | ____Medical (or healthcare) IT | ____Pharmacy |
| ____ Business Office | ____Medical Laboratory | ____Podiatry (feet) |
| ____Ophthalmology/Optometry | ____Medical Office Assistant | ____Physical Therapy |
| ____Dentist | ____Medical Security | ____Physical Therapy Assistant |
| ____ Dental Hygiene | ____Mental Health | ____Physician: Specialty _____ |
| ____Dental Assistant | ____Nursing – Hospital | ____Physician Assistant |
| ____Hospice/Palliative Care | ____Nursing – Long Term Care | ____Radiology |
| ____Hospital Administration | ____Nutrition (Dietetics) | ____Recreational Therapy |
| ____Hospital Ministry | ____Chiropractic | ____Respiratory Therapy |
| ____Social Services | ____Occupational Therapy | ____Other _____ |
| | | _____ |

(Shadowing opportunities vary by location. Certain professionals may not be available at all locations.)

**Why do you wish to shadow in these areas?**

_____

_____

_____

**The 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 Contact information:**
**Name:** _____ **Phone:**_____

Return the following completed forms: Student Information Sheet, Dress Code, Release of Liability, Confidentiality and Health Assessment forms to:

Northern Nebraska AHEC, PO Box 833, Norfolk, NE 68702 Fax: 402-383-9963

Go to www.nnahec.org under Job Shadowing, "Looking for Confidentiality & HIPAA Training" for quiz.

I submitted my HHIPAA test on this date _____/___/_____.

**FLU SHOT** verification **REQUIRED** for many locations November - March

Revised December 2022

## 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 Methodist 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 Methodist Fremont Health or Northern Nebraska AHEC. I hereby give permission for my child to participate in the Methodist Fremont Health and Northern Nebraska AHEC Student Shadow Program and I hereby release Methodist 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 Methodist 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

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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 Methodist 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 Methodist Fremont Health or Northern Nebraska AHEC. I hereby release Methodist 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 Methodist 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.

_____ _____

Signature of Student Date

# 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.

**Cell Phone Usage**

- **During job shadowing your cell phone should be turned off, left in your vehicle or with your other personal items in an assigned location at the shadowing site.**
- **Taking photos, texting, creating a video or going Live are strictly prohibited!**

COVID-19

- Shadowing students should arrive at their shadowing experience with a face mask. You must follow any face mask, handwashing/sanitizing procedures and other requirements as defined by the location. Not following the shadowing sites protocols may result in your restriction to shadow at that location and/or others.

The Shadowing contact at each location 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 _____

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**Confidentiality, Security & Information Services Job Shadow Agreement**

As student at Methodist 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 Methodist Fremont Health has a zero tolerance level for breaches in confidentiality and that Methodist 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 Methodist 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 Methodist 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 Methodist Fremont Health computer.
8. I understand that the IT department will approve software purchased for use at Methodist 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 Methodist Fremont Health and agree to turn over any keys, access cards, or any other device that would provide access to Methodist Fremont Health or its information.

_____ _____

Student Signature Date

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## 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 Methodist Fremont Health.

☐Student will be **free of communicable diseases** when observing at Methodist 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 Methodist Fremont Health's Community Engagement Specialist (402-727-3497) should they develop while onsite at Methodist Fremont Health.

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

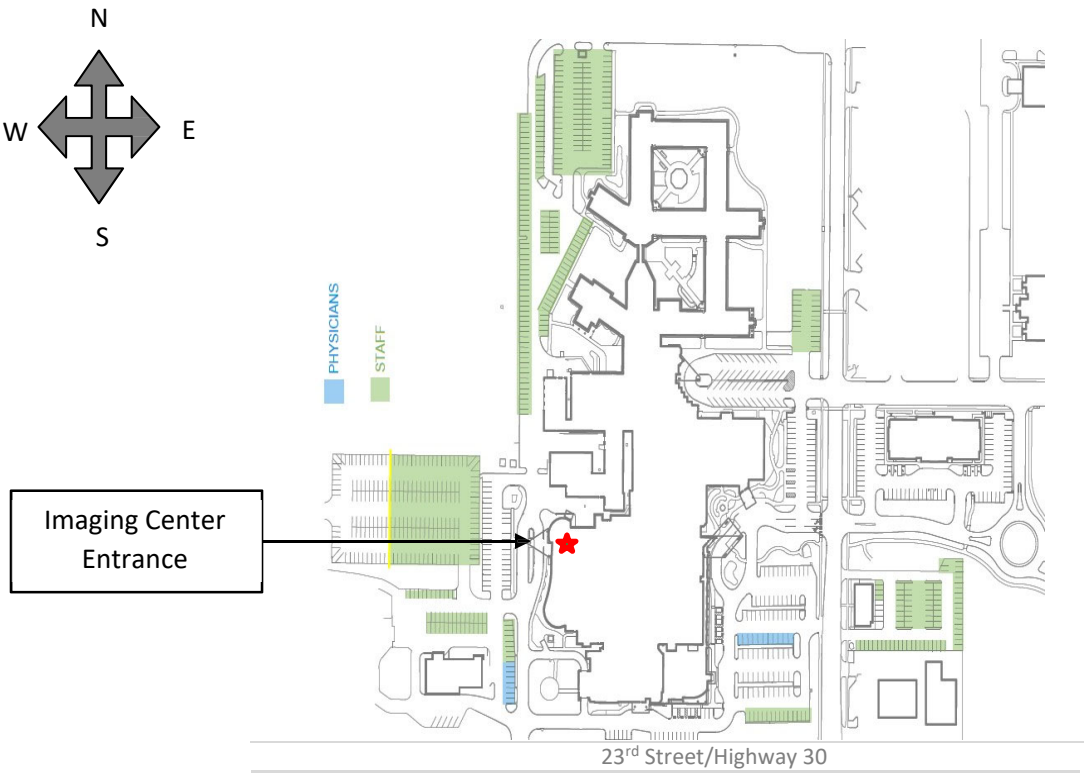
☐When returning this form, provide proof of influenza vaccination. (For shadowing dates between Nov. 1 and April 30).

Student Signature:_____Date: _____

School Nurse: _____Date: _____

# STUDENT / INSTRUCTOR ACKNOWLEDGMENT OF PARKING & ENTRANCE

As a student in an internship program at Methodist 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.




Students are only allowed to park in the green "STAFF" parking areas and enter through the Imaging Center located on the West side of the Hospital.

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.

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:_____

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## 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
- Safety Data Sheet (SDS)
- Age Specific Training
- Blood Borne Pathogens
- Back Safety
- Parking
- Patient Rights & Confidentiality
- Emergency Preparedness and Codes
- Safety Event Reporting
- National Patient Safety Goals
- Student Smoking Policy
- Student Professionalism
- Organization Chart
- Living Our Values
- 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

Or **NE Passport Completion _____**

**Student ID Badges** are required at ALL times. Students without their badge will be sent home. Proxy badge replacement cost is $7

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

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

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

Name (print): _____ Date: _____

Signature: _____ Date: _____