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

# York General Hospital
# STUDENT INFORMATION SHEET

**Please Print**

Please check one: ☐Individual Under 19 yrs of Age ☐Individual 19 years and Over

**Name:** ______________________________________________ **Date of Birth:** ______________ **Age:**________

**Address:** ________________________ **City:**_________________ **Zip**_________ **County:** __________________

**Home Phone:** ________________ **High School/College:**__________________________________________

**Email Address:** ________________________________________________ **Grade/Yr in School**______________

**Counselor/Instructor:** _________________________________________________________________________

**RACE: (Check One)** Caucasian____, African American____, Native American___, Hispanic____, Asian____, Other___
Prefer to not answer___ **GENDER:** Female__, Male__

**AREAS YOU WISH TO SHADOW** (Number 1-3 in order of preference)

__ Anesthesia (Nurse Anesthetist)
___ Business Office
___ Cardiac Rehab
___ Dialysis
___ Exercise Therapy
___ Hospital Administration
___ Medical Records
___ Nursing-hospital
___ Nursing-other sites
___ Nursing- Long Term Care
___ Nutrition (Dietetics)
___ Occupational Therapy
___ Pharmacy
___ Physician: Specialty_____________________
___ Physical Therapy
___ Physical Therapy Asst.
___ Physician Assistant
___ Radiology
___ Respiratory Therapy
___ Social Services
___ Surgery

**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 (age appropriate),
Intent of Interest and Understanding of Hospital Confidentiality to:
Katy Nun, York General Hospital, 222 N. Lincoln Ave, York, NE 68467
(402) 362-0448 or fax: (402) 362-0499

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

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

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**York General Health Care Services/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.

- 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.

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 York General Health Care Services/ Northern Nebraska AHEC Shadowing Dress Code.

Student Signature_________________________________Date _____________

(If under 19 years of age)
Parent Signature _________________________________Date _____________

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# HEALTH PROFESSIONS SHADOWING PROGRAM

## INTENT OF INTEREST / APPROVAL OF PARTICIPANTS

I _____________________________, am interested in participating in the Health Profession Shadowing Program at York General Health Care Services. The professions I am interested in shadowing are: _________________, _________________________, __________________.

______________________________________ ______________________________________

**Participant** **Advisory/Guidance Counselor Signature**

___________________

**Date**

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Approval has been authorized for the above mentioned student to participate in the York General Hospital Health Professions Shadowing Program.

____________________________________ ______________________________

**Department Director Signature** **York General Hospital Administration Signature**

_______________________

**Date**

Intent of Interest

YGH6/05

2222 Lincoln Ave ■ York, NE 68467 ■ TTD 800-833-7352 ■ Fax 402-362-0499 ■ www.yorkhospital.org

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# Understanding of Hospital Confidentiality

(Required by Nebraska and U.S. Federal Law and York General Health Care Services Policy)

**As an employee or associate (i.e. volunteer, student shadow, officer, intern, contract) of York General Health Care Services, I, the undersigned, hereby acknowledge** that I have read and understand the York General Health Care 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 York General Health Care 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 York General Health Care Services. Any patient information, computer passwords, confidential information about an employee, physician, or management and any and all financial information regarding York General Health Care Services that is made available to me as an associate or employee of York General Health Care 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 York General Health Care 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 York General Health Care 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 York General Health Care 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 York General Health Care 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 York General Health Care Services or within any of the healthcare facilities owned or managed by York General Health Care 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 York General Health Care 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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## AFFIRMATION AND RELEASE OF LIABILTY
## (Students UNDER 19 years of age)

I, ________________________________________________, the parent or legal guardian of __________________________________, a minor child, herby acknowledge that I am cognizant of and understand that there are inherent dangers in my child participating in the York General Health Care Services and Northern Nebraska AHEC Student Shadowing 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 inured patients.

In consideration of my child being allowed to participate in this program, I herby assume all risk in connection with any of the above mentioned activities, situations and being present at any of the facilities of York General Health Services or Northern Nebraska AHEC. I hereby give permission for my child to participate in the York General Health Care Services and Northern Nebraska AHEC Student Shadowing Program and I herby release York General Health Care 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 York General Health Care Services and Northern Nebraska AHEC Shadowing 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 of my own free at. 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 LIABILTY
## (Adults over 19 years of age)

I, ___________________________________, hereby acknowledge that I am cognizant of and understand that there are inherent dangers in my participating in the York General Health Care 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 York General Health Care Services or Northern Nebraska AHEC. I hereby release York General Health Care Services and Northern Nebraska AHEC, its administration, board of directors, employees, and agents from any and all liability related to my participation in the York General Health Care 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.

__________________________________________ ____________________

Signature Date