SHADOW/ OBSERVER APPLICATION

Observer Name: _____________________________ Date of Application Submission: ____________
School or Affiliation: ________________________ Reason for Observation: _____________________
E-Mail Address: _____________________________ Phone Number: ____________________________

Complete Clinical Packet includes:
☐ Shadower/Observer Application
☐ Health Screening Questions
☐ Required Immunizations (attach documentation of immunizations)
☐ “Mandatory In-service for Non-Hospital Personnel” Quiz
☐ Observer Agreement & Acknowledgement Form

Application Process

Step One

• Complete the Shadower/Observer Application
• Read the Mandatory In-Service for Non-Hospital Personnel Document before answering the quiz questions included in the application.
• Submit completed application, health screening question, proof of required immunizations, in-service quiz, and agreement and acknowledgement form to IU Health Bedford’s Student Placement Coordinator at bdfstudentplacement@iuhealth.org with the e-mail title “SHADOW REQUEST”
• Failure to complete all of the required documents above will result in a denial of the shadow/observation request.

Step Two

• You will be notified by email if IU Health Bedford is able to place you in a shadowing experience. The email will instruct you on the next steps towards the completion of your shadow experience.

________________________________________________________________________________________
This Section to be completed by IU Health Education Department
Student Placement Approval Section
☐ Mandatory Checklist – Student has completed paperwork and the program requirements.
☐ Manager Approved Opportunity – Student has been approved to begin experience.

________________________________________________________________________________________
Date: _________________ Education Coordinator: ____________________________________________

SHADOWER/OBSERVER APPLICATION
<table>
<thead>
<tr>
<th>APPLICATION QUESTIONNAIRE</th>
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<tbody>
<tr>
<td>Please answer ALL questions below and provide as much detail as possible.</td>
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1. Please choose **ONE** profession / area from this list.  
   - [ ] Administration  
   - [ ] Cardiac Rehabilitation  
   - [ ] Emergency Department  
   - [ ] Environmental Service (Housekeeping)  
   - [ ] Food and Nutrition  
   - [ ] Intensive Care Unit  
   - [ ] Laboratory Department  
   - [ ] Medical Surgical  
   - [ ] Occupational Therapy  
   - [ ] Oncology  
   - [ ] Outpatient Surgery (does not include operating room)  
   - [ ] Physical Therapy  
   - [ ] Radiology Department  
   - [ ] Speech Therapy  
   - [ ] Volunteer Services  
   - [ ] Other ______________________

2. If you have a specific focus of the profession / area you have chosen to shadow, please describe your interest here.  

3. Explain specific length of request.  
   (Maximum is 24 hours but will vary by department.)  
   *(Example: I would like to complete 10 hours before 7/31.)*

4. List very specific details of your availability (days and times) during the spring/summer (April to Aug). Consider class and work schedules, travel time, etc. Also list specific dates you are not available due to exams, school breaks, vacations, etc.  
   *(Example: I am available Mon. 7:30-4:30, Tues. & Thurs. 8:00am–11:30am, not available July 1-5) Also indicate preferred month(s) you wish to shadow.*

5. Have you ever been convicted of a felony or misdemeanor that has not been expunged (erased or stricken) by a court?  
   - [ ] Yes *(Checking yes will not automatically disqualify you from consideration.)*  
   - [ ] No

6. If the answer to question #5 is yes, list the violation and date of conviction or plea. Must include a detailed explanation.
SHADOWER/OBSERVER PACKET

Please complete this packet and carefully read the policy references as they are important to make your experience safe for our patients, staff, and you!

By signing the statement at the end of this packet, you agree that you understand these policies and agree to abide by them. Therefore, please carefully read all items before signing the checklist at the end of this packet.

1. Observer Information
Name: ___________________________________________________________________________________

First  Middle  Last

___Female  ___Male  ___Prefer not to disclose

Permanent Address: _________________________________________________________________________
City: _____________________________ State: _______________ Zip: _______________________________

Date of birth: _______/_______/_______ Social Security Number: _________________________________

In an Emergency Notify:
Name: _____________________________________  Phone: (_____)_____________________________
Relationship to you: __________________________ Cell: (_____)___________________________

2. Health Screening Questions
As IU Health Bedford develops contracts with higher education health care focused student programs, it is important to assure that State and Federal health care worker requirements are met. Because the vaccine preventable disease and TB status of students are also infection control issues, the Infection Control Nurse and the Employee Health Services of IU Health Bedford was consulted in the development of recommendations listed below. The same employee vaccine and TB testing standards apply to students. Individuals who respond “yes” to following questions must be cleared by the Employee Health Services prior to beginning activities at IU Health Bedford.

Screening Questions: Must Circle One (Yes or No) for each question:
I have had contact with an individual:
1. With active tuberculosis within the last 12 weeks…………………………………………………..Yes / No
2. With active case of chickenpox within the last 30 days…………………………………………..Yes / No
3. That has/had a communicable disease within the last 30 days (i.e. SARS, Measles, etc.)…………Yes / No
If yes, please explain: ________________________________________________________________

I currently have the following symptoms:
1. Persistent productive cough of 2 weeks or longer………………………………………………..Yes / No
2. Night sweats…………………………………………………………………………………………Yes / No
3. Fever……………………………………………………………………………………………………Yes / No
4. Open skin lesions………………………………………………………………………………………Yes / No

3. Required Immunizations
Proof of immunizations or immunity (positive titers) must be submitted with this paperwork.
- MMR:
  - Documentation of 2 MMR
Varicella (Chickenpox):
- I have provided documentation of a positive Varicella IgG blood test with this packet.
- Vaccinated Student: I have been vaccinated with two doses of varicella vaccine (Varivax) at least one month apart, and have provided the record with this packet. I understand that breakthrough infections (cases of chickenpox) have occurred among vaccinated individuals after exposure to individuals with chickenpox disease. It is my responsibility to immediately notify IU Health Bedford Employee Health Services of chickenpox exposures at or away from the facility.

Hepatitis B Vaccine:
- I have provided documentation with this packet of completion of the three-step Hepatitis B Vaccine series and a positive Hepatitis B surface Antibody blood test (drawn at least 4 weeks after the third vaccination).
- I am currently receiving the Hepatitis B vaccine series. I will provide documentation of completion of the three-step Hepatitis B vaccine series and a positive Hepatitis B surface antibody blood test drawn at least 4 weeks after the third vaccination.
- I decline the Hepatitis B Vaccine because (circle one): (Signature required below)
  a. I understand that, due to my occupational exposure to blood and other potentially infectious materials, I may be at risk of acquiring Hepatitis B Virus (HBV) infection. IU Health Bedford has strongly advised that I visit a healthcare provider and obtain the Hepatitis B Vaccine. However, I decline Hepatitis B Vaccination at this time. I understand that by declining this vaccine I continue to be at risk of acquiring Hepatitis B, a serious disease.
  b. The vaccine is contraindicated for medical reasons. Explain:________________________________________
  c. I do not anticipate occupational risk of exposure to blood and other potentially infectious materials
  d. Signature required for declination________________________________________

Tetanus, Diphtheria, Pertussis Vaccine (Tdap) Adecel:
- Yes, I have provided documentation of Tdap vaccine
- I have provided a medical waiver due to personal health history

Influenza (Flu) Vaccine:
- I have provided documentation of a current flu vaccination (given during this season)

Tuberculosis Screening:
- Documentation of a negative (Omm) TST within the past 12 months (must include date & time of placement & reading), and one negative (Omm) TST immediately prior to starting clinical.
- Two negative (Omm) TSTs completed, 1-3 weeks apart, immediately before starting clinical.
- Documentation of T-SPOT or quantIFERON – TB Gold blood tests for TB screening within 30 days of start date

Documented History of positive Tuberculosis Skin or Blood Test:
- Negative chest x-ray, followed by annual screening for signs and symptoms of active tuberculosis disease.
Influenza Vaccination Policy for Observers:

A note to all observers participating in learning experiences at IU Health Bedford Hospital, including both clinical and non-clinical student shadow experiences, regarding the Influenza Vaccine Policy:

The Indiana University System has enacted an Influenza Patient Safety Program. The goal of this program and policy is to minimize or eliminate the spread of influenza within the IU Health facilities. This policy affects all employees, physicians, volunteers, contract employees, and students regardless of clinical area and regardless of whether the student is a shadow or clinical student.

This policy will require that all observers that are participating in a shadow or clinical experience at IU Health show positive proof of influenza vaccination by December 15th of each calendar year. There are very limited medical and religious exemptions to this policy. The currently approved list of medical contraindications to receiving the influenza vaccines include:
  ❖ Severe (life threatening) allergy to any component of the vaccine, including allergy to eggs).
  ❖ A documented previous severe reaction after a dose of influenza vaccine
  ❖ History of Guillain-Barre Syndrome within 6 weeks of influenza vaccine

Observers who believe they have a valid reason to be made exempt from taking an influenza vaccination must complete an Influenza Exemption Request from and submit the completed form to the Education Department at IU Health Bedford no later than October 1st of the current calendar year. The Influenza Exemption Request Form can be obtained by contacting the Education Department at IU Bedford. Contact information is listed below. The completed exemption forms will be reviewed by the Exemption Review Team within the IU Health System and the student will be notified of acceptance or refusal to be allowed to serve in the role of student, non-vaccinated. This notification will take place no later than October 30th. If the exemption is denied the student must either be vaccinated or he/she will not be allowed to shadow or participate in their clinical experience. Any student that does not show proof of vaccination by December 15th of each calendar year, will be removed from his/her shadow or clinical experience.

If you have any questions regarding this policy, please contact the Education Department at IU Health Bedford Hospital by using the contact information listed

Thank you for your assistance in compliance with the Influenza Vaccination Policy.
“Mandatory In-service for Non-Hospital Personnel” Quiz
Please read the In-Service for Non-Hospital Personnel prior to answering the quiz questions.

1. Students can be dismissed from a shadowing or clinical experience for violating the hospital’s Tobacco Free Campus Policy.
   a. True
   b. False

2. Personally identifiable information includes which of the following?
   a. Name
   b. Date of Birth
   c. Driver’s License Number
   d. All

3. If a patient discloses personal information to a healthcare provider, the healthcare provider may reveal this information to anyone without the consent of the patient.
   a. True
   b. False

4. Every patient has a right to receive considerate and respectful care.
   a. True
   b. False

5. Students are not held to the same standards as employees with regards to posting confidential information on social networking sites, such as Facebook or Twitter.
   a. True
   b. False

6. Cases of suspected child abuse or neglect can be reported to which of the following?
   a. IU Health Bedford Social Services
   b. Indiana Division of Family & Children
   c. both

7. Who is responsible for maintaining patient privacy and confidentiality?
   a. Medical Records
   b. Physicians
   c. Everyone
   d. Registration Staff

8. How do you report a fire?
   a. Call 199 and state “Fire Alert, your location, and your name”
   b. Yell down hallways to alert staff and visitors.
   c. Call the operator by dialing “0”.
   d. Don’t worry. Someone else will do it.

9. The letter R of the RACE acronym of the fire plan stands for:
   a. Run
b. Remove anyone in danger
c. Relax
d. Realistic

10. An “Active Threat” is implemented when the following happens:
   a. A patient threatens to leave against medical advice
   b. A person’s behavior (patient, staff or visitor) becomes threatening in nature and they have a weapon that they seem prepared to use against another person
   c. There is a confirmed report of a tornado being sighted and the Bedford area is in imminent danger
   d. An external disaster has occurred

11. Universal Precautions include which of the following actions:
   a. Hand washing before and after every patient contact
   b. Treating all blood and body fluids as if they are infect
   c. Disposing of all needles in the red sharps container
   d. All of the above

12. Students are not required to wear a hospital issued ID badge:
   a. True
   b. False

13. SDS Sheets provide information about the health hazards, precautions for safe handling, and emergency first aid procedures to use for chemicals.
   a. True
   b. False

14. All new electrical equipment must be evaluated prior to use by:
   a. Engineering
   b. Risk Management
d. The State Fire Marshall
   c. Joint Commission on Accreditation of Healthcare Organizations

15. A student can be dismissed from their clinical or shadowing experience if they violate which of the following policies:
   a. Student Standards of Conduct
   b. Alcohol and Drug-Free Workplace Policy
   c. Harassment and Workplace Violence Prevention Policy
   d. Any of the above

16. Handwashing is the single most important thing you can do to prevent the spread of infection.
   a. True
   b. False

17. Always wash your hands:
   a. Before you eat
   b. After using the toilet
   c. After blowing your nose, sneezing or coughing
d. After touching things that belong to another patient or a visitor
e. All of the above

6. Observer Agreement & Acknowledgement Form:

Confidentiality Agreement  Initial________
As an observer at IU Health Bedford, I recognize the extreme importance of confidentiality with respect to information concerning patients, IU Health Bedford operations, and employees / Human Resources. I acknowledge that I will adhere to the provisions of the Health Insurance Portability and Accountability Act (HIPAA) and any other federal or state laws regarding confidentiality. I understand that violations of confidentiality may result in legal action pursuant to HIPAA and other applicable state and federal laws.

- All patient information (including personal, financial, and health information), as well as all information regarding IU Health Bedford operations and employees / human resources, is confidential and any inappropriate viewing, discussion, or disclosure of this information is a violation of IU Health Bedford policy.
- This information is privileged and confidential regardless of format: electronic, written, overhead or observed.
- I understand that violations of confidentiality will result in disciplinary action up to and including termination of employment, contract, association, or appointment. Disciplinary action may also include the imposition of fines and other legal action pursuant to HIPAA and other applicable state and federal laws.
- I agree to report any violations of confidentiality that I become aware of to my supervisor, department director, member of the Senior Leadership Group, or the HIPAA Privacy Officer.
- I have read and understand the information outlined in the “Confidentiality” section of the “Mandatory In-service for Non-Hospital Personnel.”

Ethics – Professionalism  Initial________
I understand, like staff, I cannot initiate telephone calls, write notes, or arrange social interactions with patients. I will clearly define boundaries of staff-patient relationships during chance meetings in the community. Any pre-existing relationships with patients are to be discussed with the Director of the Department. Should a discharged patient attempt to develop a personal relationship with me post-discharge, I will clearly define again the staff-patient relationship boundaries and report this to the Director, who will provide specific guidance for professional conduct. Violation of this policy is grounds for termination of my Shadowing experience.

Hold Harmless Agreement & Waiver  Initial________
The undersigned, being an adult, does hereby agree to release, indemnify, and hold harmless IU Health Bedford, its employees, agents, and representatives from any and all damages of any nature whatsoever which the undersigned may suffer as a result of being a passenger in a IU Health Bedford vehicle, including an IU Health Bedford emergency vehicle, owned or operated by IU Health Bedford. The undersigned fully understands the risks involved in being a passenger in an IU Health Bedford vehicle, including an IU Health Bedford emergency vehicle owned or operated by IU Health Bedford, and assumes risk freely and voluntarily. This release indemnity and holds harmless is given by the undersigned in consideration of IU Health Bedford granting permission to ride in an IU Health Bedford vehicle, including an IU Health Bedford emergency vehicle, owned or operated by IU Health Bedford, for training, observation and evaluation purpose of benefit to the undersigned. In addition the undersigned releases and holds harmless IU Health Bedford Hospital and IU Health Partners and any and all of its agents,
representatives, employees, subsidiaries; from any accident, injury, or wrongful action on my part that might occur as a result of my participation in the event/program in which I am participating. The undersigned further understands that their participation in this event/program is of their own free will.

**Model Release**  Initial______
I hereby give IU Health Bedford Hospital permission to use images of me (photos, video footage, etc.), and to publish it without incurring any debts or liabilities of any kind. I understand that these images may be used in IU Health Bedford Hospital publications. Although it is anticipated that my image will appear in only one type of medium (print publication), there is a chance that it may be used in other media as well (IU Health Websites or in an IU Health Bedford Hospital future publication), if the facility deems it appropriate. I understand that I will not be reimbursed for the use of images that include me in them.

**Smoking & Tobacco Use Policy**  Initial______
Smoking and/or use of tobacco products will not be allowed on the IU Health Bedford campus (including: in buildings or in vehicles owned and operated by IU Health Bedford). This includes all satellite buildings and the property associated with those satellites. All tobacco products, including chewing tobacco and snuff, are included in the policy. Violation of this policy may result in termination of Clinical experience.

**Personal Appearance & Dress Code**  Initial______
As a Clinical Student you are expected to follow the dress code recommendations outlined in the Professional Appearance Chart. Items NOT allowed under dress code: denim jeans, shorts, sleeveless blouses, sandals, or any attire that shows undergarments. Jewelry and perfume scents should be kept to a minimum. Items recommended: appropriate scrubs (check with assigned area to determine color of scrubs) or business casual attire (Example: khaki pants, a nice shirt, clean & comfortable tennis shoes).

**Read this statement carefully before signing:** All preceding answers in this packet are true to the best of my knowledge and I understand this will become a part of my record. I also understand that any incorrect, incomplete, false, or misleading statement or information by me herein will be considered possible cause for my dismissal from my student experience. Furthermore, I understand that the Health Screening is not a physical examination. The hospital is not assuming responsibility for my continued medical care. I have read and understand the preceding policies. I am aware that if I violate an IU Health Bedford rule or regulation my clinical experience may be terminated immediately. Additionally, if I do not meet the Professional Appearance & Dress Code Policy on days in which I am scheduled for my Clinical I will not be allowed to complete the experience on that day. I will remember that the department may make special accommodations for my clinical experience. Therefore, if something happens and I am not available during the time that I have been scheduled for, then I MUST notify the department. Rescheduling arrangements may be discussed at this time or later.

Observer Signature  Student Printed Name  Date

If the student is under the age of 18 a parent or guardian signature is required as well.

Parent/Guardian Signature  Parent/Guardian Printed Name  Date