Indiana University Health

Observer/Shadow Application

Legal Name (First-Middle Initial-Last):		
Preferred Name for Name Badge:		
Current Address:		
City:	State:	Zip:
Permanent Address (if different from current):		
City:	State:	Zip:
Contact Phone Number:		
E-Mail Address:		
Date of Birth (Must show proof, i.e. drivers license)		
In an emergency, notify (name & relationship):		
Emergency Contact Phone Number:		

*Note: Shadowing experiences are limited to up to 24 hours per department or unit and are observation only. Departments may set a more restrictive limit on the 24-hour maximum, but may not allow more observation hours beyond the 24-hour maximum.

Please check any applicable boxes below indicating why the experience is needed/requested.

☐ Prerequisite for application to a degree program—Need experience to be considered for a program and will not be sponsored by a school.
☐ Required experience for a current class or program—Already enrolled in the class or program and need experience for completion or requirement.
☐ Personal experience not related to school requirements.

Completed Observer Packet will include:

1. Observer/Shadow Application:
   - Observer Information + Emergency Contact Information
   - Observer Application Questionnaire
   - Health Screening Questionnaire
   - Required Immunization Checklist (proof/documentation must be provided)
   - Observer/Shadow Agreement & Acknowledgement
2. Facility Specific Non-Hospital Personnel Observer Orientation Information (may include quiz)
3. Hand Hygiene Information (may include quiz)

OBSERVER APPLICATION QUESTIONNAIRE

Please answer ALL questions below and provide as much detail as possible.

1. Please choose **ONE** profession / area from this list, or write your choice into the "Other" section provided.	☐ Certified Tumor Registrar ☐ Dietician ☐ Emergency Medical Technician / Paramedic ☐ Health Information Management Services (medical records, coding, transcription) ☐ Laboratory Services ☐ Patient Accounts (billing and collections) ☐ Patient Registration	☐ Pharmacy ☐ Phlebotomist ☐ Public Health Services ☐ Radiation Therapist ☐ Radiology Technologist ☐ Registered Nurse ☐ Respiratory Therapist ☐ Social Worker/Counselor ☐ Surgical Technologist 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 10/31.)*		
4. List very specific details of your availability (days and times) during the academic year. 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 Nov. 20-24)*	
5. Have you ever been convicted of a felony or misdemeanor that has not been expunged (erased or stricken) by a court?	☐ Yes ☐ No (Checking yes will not automatically disqualify you from consideration.)	
6. If the answer to question #5 is **yes**, list the violation and date of conviction or plea. Must include a detailed explanation.		

OBSERVER APPLICATION QUESTIONNAIRE

Please answer ALL questions below and provide as much detail as possible.

HEALTH SCREENING QUESTIONNAIRE

Please answer ALL questions below and provide as much detail as possible.

I have had contact with an individual with active tuberculosis within the last 12 weeks.	☐ Yes ☐ No
I have had contact with an individual with an active case of chickenpox within the last 30 days.	☐ Yes ☐ No
I have had contact with an individual 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 a persistent productive cough of 2 weeks or longer.	☐ Yes ☐ No If Yes, please explain:
I currently have night sweats.	☐ Yes ☐ No If Yes, please explain:
I currently have a fever.	☐ Yes ☐ No If Yes, please explain:
I currently have open skin lesions.	☐ Yes ☐ No If Yes, please explain:

REQUIRED IMMUNIZATION CHECKLIST- For review only **Must provide proof/documentation of following:**	
Hepatitis B	☐ Not required, but recommended. ☐ All Observers will be required to complete the Hepatitis B Accept/Decline form.
MMR Evidence of Immunity	☐ Documentation of two (2) doses of MMR (measles, mumps, and rubella) separated by at least 28 days, **or** ☐ Documentation of laboratory (blood test) evidence of measles, mumps and rubella immunity (Positive Rubeola IgG, Mumps IgG, and Rubella IgG)
Varicella (Chickenpox) Evidence of Immunity	☐ Documentation of two (2) doses of Varicella vaccine given at least 28 days apart, **or** ☐ Documentation of laboratory (blood test) evidence of immunity (Positive Varicella IgG).
Tetanus, Diptheria, Pertussis (Tdap)	☐ Not required, but recommended.
Tuberculosis (TST) TB Skin Testing	☐ **Initial Testing**: If the observer/shadow does not have evidence of a negative TB screening within the past 12 months, they must submit to an IGRA blood test or a TBT (Tuberculin Skin Test). ☐ **History of negative TB screening within 12-months prior to observation start date:** ☐ Documentation of negative 2-step TB skin testing: A 0mm TST within 12 months prior to the observer/shadow's start date will be accepted as the first of two required TSTs. If the observer/shadow experience extends beyond 30-days in a 12-month period, the second TST must be completed within the first 30 days after the observer/shadow's start date. ☐ Documentation of negative IGRA: A negative IGRA blood test will be accepted within 12 months prior to the observer/shadow's start date. ☐ **Positive TB Skin Test History**: If observer provides a reliable history of a positive TB test, they may not begin their observer/shadow experience, and must report to EOHS for follow up instructions.

Influenza	☐ If the observer/shadow will be in an IU Health facility during the months of September through March 31, they **must** show evidence they received the flu vaccine. Documentation must include: Date given, Manufacturer, Type of vaccination, Lot number, Expiration date, and Name and credentials of person who administered the shot.
COVID-19	☐ Not required, but recommended.

OBSERVER/SHADOW AGREEMENT & ACKNOWLEDGEMENT

ETHICS – PROFESSIONALISM

I understand that unlike 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 placement experience. I will not take any pictures of patients or staff. I will not put patient information on any social media site.

CONFIDENTIALITY

As a Non-Hospital Personnel/Visitor at IU Health I recognize the extreme importance of confidentiality with respect to information concerning patients, IU Health 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 will result in disciplinary action up to and including termination of 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 Chief Privacy Officer. I have read and understand the Privacy education provided in the Non-Hospital Personnel Education In-Service.

HOLD HARMLESS

The undersigned, in return for being allowed to participate in certain IU Health activities agrees to assume the risks of participating in these activities and does herby agree to release, indemnify and hold harmless IU Health, its employees, agents and representatives, from any and all damages of any nature whatsoever which the undersigned may suffer as a result of these activities such as being a passenger in an IU Health vehicle, including an IU Health Emergency Medical Transport Services emergency vehicle, owned or operated by IU Health. The undersigned fully understands and assumes the risks involved in being a passenger in an IU Health vehicle, including an Emergency Medical Transport Services emergency vehicle owned or operated by IU Health, and assumes risk freely and voluntarily. These risks include an increased risk of injury and even death from being a passenger in a vehicle and/or in an emergency vehicle responding to an injury, accident or illness in an emergent fashion. This assumption of risk, release, indemnity and holds harmless is given by the undersigned in consideration of IU Health granting permission to ride in an IU Health vehicle, including an Emergency Medical Transport Services emergency vehicle, owned or operated by IU Health for training, observation and evaluation purpose of benefit to the undersigned.

Model Release

I hereby give IU Health 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 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 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

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

Personal Appearance & Dress Code

As an Observer/Shadow, 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), school assigned uniform or business casual attire (Example: khaki pants, a nice shirt, clean & comfortable tennis shoes).

READ THIS STATEMENT CAREFULLY

All the information in this packet is 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 placement 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 rule or regulation my placement as a non-hospital personnel or visitor may be terminated immediately. Additionally, if I do not meet the required Dress Code Policy required of me on days in which I am scheduled, I will not be allowed to complete my duties on that day. I will remember that the department may make special accommodations for my placement. Therefore, if something happens and I am not available during the time that I have been scheduled for, then I MUST notify the department and/or my assigned IU Health contact. Rescheduling arrangements may be discussed at this time or later.

OBSERVER/SHADOW AGREEMENT & ACKNOWLEDGEMENT

I have read, acknowledged, & agree to abide by the following: (check or highlight boxes & sign below)

- ☐ I will keep all Protected Health Information and Business Operations Information confidential.
- ☐ I will follow all immunization, health, and safety standards.
- ☐ I will remember that we live and practice in a diverse community and I will treat all people with respect.
- ☐ I will hold harmless IU Health and its representatives from any damages obtained during my placement.
- ☐ I will not use tobacco products or smoke on the IU Health campus.
- ☐ I will follow the Professional Image and Dress Code Guidelines as detailed in this application.
- ☐ I have reviewed the National Patient Safety Goals included in the Observer orientation information.
- ☐ I will remember the IU Health Values (Excellence, Purpose, Team, Compassion) and will treat everyone that I encounter with respect.

Please read carefully before signing:

I have read and understand the observer/shadow Inservice and have completed the Observer Placement Application to the best of my ability. I voluntarily authorize Indiana University Health to make a thorough investigation of my eligibility for a shadowing experience. I agree to meet all applicable immunization requirements before beginning my placement. I understand that my placement may be terminated for any misinformation and/or omission of facts appearing on the application form, or for any violation of rules or regulations.

[signatures on next page]

Signature: **Date:**
(Observer)

Signature: **Date:**
(If under 18 years of age the Parent/Guardian of Observer must also sign here)

Observer Liaison Signature: **Date:**