Indiana University Health
SOUTH REGION

SHADOWING
STUDENT PLACEMENT APPLICATION
2026

Legal Name (First, Middle Initial, Last):		
Preferred Name for Name Badge:		
Current Address:		
City:	State:	Zip:
Phone Number:		
E-Mail Address:		
University/College/Program/School (if applicable):		
Year in School and Major (if applicable):		
Date of Birth:		
In an Emergency, Notify (name & relationship):		
Emergency Contact Phone Number:		

PLEASE NOTE BEFORE CONTINUING:

- Shadowing experiences are strictly observation only. You cannot work or do any type of task.
- If you request to shadow with a Physician, Physician Assistant or Nurse Practitioner: Include on the application or in an email your school name, year in school, major and a brief explanation for your request (i.e. why do you want to shadow with a provider: school requirement, school application, personal experience…)
- Shadowing experiences are limited to 1-3 specialties in a 12-month period with a maximum of 24 observation hours. Maximum number of hours may vary by unit/department and role and are not guaranteed.
- Shadowers must be at least 16 years of age and 18 years of age for OR/surgery areas.

Please check 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 class completion or degree requirement.
☐ Personal experience not related to school requirements.

IU HEALTH PAOLI HOSPITAL
SHADOW APPLICATION QUESTIONNAIRE
Please answer ALL questions below and provide as much detail as possible.

1. Please choose **ONE** profession/ area from the options listed:	☐ Med-Surg RN ☐ Emergency RN ☐ Obstetrics RN ☐ Phlebotomist ☐ Radiology Technologist ☐ Respiratory Therapy	☐ Surgical Technologist ☐ Surgical RN ☐ Physical/Occupational Therapy ☐ Pharmacy Technician ☐ Visiting Specialist MA or RN ☐ Other: List details in box #2
2. If you have a specific focus of the profession/area you have chosen to shadow, describe your interest here. If you have already been accepted by an IU Health team member to shadow, provide all details including name & location.		
3. Explain specific length of request. Maximum is 24 hours but will vary by department and role. *(Example: I would like to complete 10 hours before 8/31.)*		
4. Provide very specific details of your availability (days and times). List if you can shadow during summer/fall/spring semesters. 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 March 14-22)*	
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.		

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:

SHADOW AGREEMENT & ACKNOWLEDGEMENT FORM

ETHICS – PROFESSIONALISM

I understand, like team members, 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 or Manager 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 or Manager, 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 shadower/observer at IU Health South Region, I recognize the extreme importance of confidentiality with respect to information concerning patients, IU Health operations, team members and workforce members. 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 current and future placement. 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.

PROFESSIONAL IMAGE

As a shadower/observer you are required to follow the dress code set forth by IU Health. In summary, you are required to wear business casual attire. Items recommended include dress pants, khaki-type casual slacks, collared shirt, dress shirt, blouse, sweater, with clean and comfortable closed-toe flat dress shoes or athletic shoes with socks or hosiery. Items **NOT** allowed include jeans, shorts, sleeveless blouses, t-shirts, sweatshirts, sandals. If you do not meet the dress code requirement, you will not be able to observe/shadow on that day and your placement will not be rescheduled.

HOLD HARMLESS

The undersigned, being an adult or having a parent guardian sign the release form, in return for being allowed to participate in an observation experience at IU Health, agrees to assume the risks of participating in this experience and does hereby agree to release, indemnify and hold harmless IU Health South Region, its employees, agents and representatives, from any and all damages of any nature whatsoever which the undersigned may suffer as a result of this experience. This assumption of risk, release, indemnity and holds harmless is given by the undersigned in consideration of IU Health South Region.

MODEL RELEASE

I hereby give IU Health 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 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

Smoking, vaping, and the use of tobacco products is NOT allowed on the IU Health campus. This includes all hospitals, satellite buildings, outpatient buildings and all property associated with these buildings. All tobacco products, including chewing tobacco, snuff, electronic cigarettes and vapes are included in this policy. Violation of this policy may result in termination of the shadower/observer experience.

READ THIS STATEMENT CAREFULLY

All the information in this application 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. IU Health is not assuming responsibility for my 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 shadower/observer may be terminated immediately. Additionally, I will remember that the department may make special accommodation for my placement. Therefore, if something happens and I am not available during the time that I have been scheduled, I MUST notify the department and/or my assigned IU Health contact. Rescheduling arrangements may be discussed at this time or later.

SHADOWER/OBSERVER AGREEMENT

I have read, acknowledge and agree to abide by the following: check or highlight boxes and 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 South Region and its representatives from any damages obtained during my placement.
☐ I will not use tobacco products, smoke or vape on the IU Health campus.
☐ I will follow the Professional Image and Dress Code guidelines as detailed in this application.
☐ I will remember the Standards of Assurance (quality, communication, environment, accessible) and will treat everyone that I encounter with respect.
☐ I understand that a shadowing experience is observation only.

PLEASE READ CAREFULLY BEFORE SIGNING

I have completed the Shadowing Application to the best of my ability. I voluntarily authorize Indiana University Health South Region to make a thorough investigation of my eligibility for a shadowing experience. I agree to meet all 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.

My signature below indicates that I agree and understand the information contained in this application and agree to the items listed above in the Shadower/Observer Agreement.

Signature: **Date:**
(Your typed legal name qualifies as an electronic signature.)

If shadower is under 18 years of age, parent/guardian of shadower must provide name and signature:

Parent/Guardian Name:

Signature: **Date:**
(Your typed legal name qualifies as an electronic signature.)

***Submit completed application by email to Student Placement Services:**

e-mail: paostudentplacement@iuhealth.org

QUESTIONS?
Please contact Student Placement Services at
812.723.7523 or PAOStudentPlacement@IUHealth.org

IU HEALTH IMMUNITY, VACCINATION AND TB TESTING REQUIREMENTS Before shadowing/observing with IU Health, you must submit records of the following requirements. Non-Workers including shadowers/observers are required to meet the same health requirements as employees of IU Health. Health requirements are established in response to current CDC and Indiana State Department of Health guidelines and requirements.	
Hepatitis B	• Documentation of completed 3 shot series **OR** • Documentation of positive Hepatitis B Surface Antibody blood test **OR** • Declination Form (ask IU Health Student Placement for the 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 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 follow up with Employee Health for instructions.
Influenza Vaccination	• Required from November 1 through March 31. Documentation must include: Date given, Manufacturer, Type of vaccination, Lot number, Expiration date, and Name and credentials of person who administered the vaccine.
COVID Vaccination	• Not required, but recommended