Adult Job Shadow Program

Job Shadow Description:

At Ochsner Health, we have a structured job shadowing program that allows individuals an opportunity to shadow a physician, advanced practice provider, or other healthcare professional for no more than 5 days in a year. (Shadowing days are usually a half day and cannot exceed 8 hours.) If you would like to have a more extended experience, we encourage you to apply for the volunteer program.

Any adult who currently desires to seek further insight into a particular department to gain personal understanding and general knowledge related to job function and environment is invited to apply for a job shadow experience. Participants must be at least 18 years of age and fully vaccinated for COVID-19 to participate.

Purpose:

Job shadowing is an educational experience option in which participants learn about a job by walking through the workday as a shadow to an employee. The job shadowing education experience is temporary, unpaid exposure to the workplace in an occupational area of interest to the participant. Participants witness firsthand the work environment, employability and occupational skills in practice, the value of professional training, and potential career options. Job shadowing is designed to increase career awareness, help model Participant behavior through examples, and reinforce in the Participant the link between classroom learning and work requirements.

Behavioral Standards:

- Participants will be respectful and courteous to patients, family members, and staff at all times.
- Participants will not touch patients. If participants are allowed to observe a patient during a procedure, the director or manager must obtain the patient's consent first, or if the patient does not have capacity, the director or manager must obtain the consent of the patient's legal representative.
- Participants will not make any decisions regarding or render any advice or recommendations as to the treatment or care of patients.
- Participants will not touch medical equipment.
- Participants will not have medical record, chart, or computer access.
- Participants will not assist in feeding a patient but may assist in food delivery.
- Participants will not approach physicians about personal illness or medications.
- Participants will dress professionally. NO jeans or shorts; scrubs or lab coats; sandals or flip-flops; dangling jewelry.
- Participants will not be permitted to wear scrubs or lab coats, as they are reserved for the care provider team.
- Participants will not perform personal care in the clinical setting (i.e., eating or drinking, brushing hair, etc.)
- Participants will not be permitted in areas of contamination, such as isolation rooms, soiled linen areas, labs, and autopsy rooms.
- Participants cannot participate in the program on days they are ill, including but not limited to, Cold/Cough, Fever (must be fever-free for 24 hours), Chicken Pox, Pertussis (Whooping Cough), Influenza (Respiratory Flu), Stomach/Gastrointestinal Flu, Tuberculosis, MRSA.
- Participants will not need a purse, cell phone, or backpack; no storage will be available on-site for personal items.
- Cell phone use is not permitted.
- Ochsner is not liable for any theft of or damage to personal property while you are on campus for your job shadow. It is best to leave important personal items at home.

If interested in a Job Shadow experience at Ochsner, please review the educational PowerPoint, then complete and submit the following forms to Kristi.suprean@ochsner.org:

1. Job Shadow Application
2. Participant Agreement/Release
3. Confidentiality Agreement
4. Completion of health screening requirements (ReadySet profile, health surveys, and vaccinations)

You will be contacted as soon as a mentor is identified to discuss your schedule availability.

For any questions, please call 985-646-5021 or email Kristi.Suprean@ochsner.org

Adult Job Shadow Application

Participant Contact Information

Name _____
Last First Middle

Home Address _____
Street Number Street Name Apt City State Zip

E-Mail Address_____@_____._____

Birth Date _____/_____/_____ Phone Number (_____) _____–_____
Month Day Year

Emergency Contact Information

Name _____ Relationship _____

Primary Phone (_____) _____–_____

Placement Information

Classification: ☐ College Student ☐ Post-Graduate/Professional

In what field of study/department/career are you looking to complete your job shadow?

_____

Do you already have a mentor confirmed? ☐ YES ☐ NO

(If yes) Mentor's Name: _____ Department: _____

Job shadow opportunities are provided without regard to religion, creed, race, national origin, age or sex. This application is submitted with understanding that approval from the authorized Ochsner designee must be in place prior to commencing the shadow as a condition to begin. I certify that the answers given to the foregoing statements are correct and without omission. I authorize the company to investigate the foregoing; and my former employers from any liability for damage, which may result from any such investigation. If upon investigation, anything contained in this application is found to be untrue, I understand I will be subject to dismissal at any time during the period of shadowing. Ochsner is not obligated to provide a placement, nor am I obligated to accept the placement offered. I understand that if accepted, I will schedule my placement in a timely manner. I also understand that I will not be paid for this experience.

_____ _____ _____
Participant Signature Participant Printed Name Date

Health Career Exploration/Job Shadow
Participant Agreement

I, _____, have been selected to participate in a job shadow to
(***Print Participant Name)***
seek further insight into a particular department in order to gain personal understanding and general knowledge related to job function and environment.

Consent: I give permission to have myself photographed and/or videotaped while participating in any Program by Ochsner Clinic Foundation and all its affiliates* (together "Ochsner") for use by Ochsner in all public relations activities, including use by or for news media, and further authorize the use of my name with said photos, film, print or tape in all advertising activities, including television commercials, print ads, brochures, web sites, and outside billboards.

Release. In consideration of being allowed to participate in the Volunteer Program, I hereby release Ochsner Clinic Foundation, as well as its subsidiaries, affiliates, representatives, agents, physicians, employees, servants, officers, directors, insureds, insurers, successors, and assigns (collectively "Ochsner") from any and all liability for any injury or damage which may occur as a result of my participation in the Program including all risk connected therewith, whether foreseen or unforeseen; and further, agree to save and hold harmless Ochsner from any claim by myself individually or on behalf myself, family, estate, heirs or assigns arising out of my participation in the Program.
In the event of an injury requiring medical attention, I hereby grant permission to Ochsner to provide initial medical services to me. If the injury warrants further medical attention, and my specific authorization is unable to be obtained before action is taken, I grant permission for necessary medical treatment to be given. In addition, I hereby give my permission to the supervising instructor(s) or Ochsner staff (including medical staff) to take me to the appropriate medical department for treatment within the hospital or, if a physician, to administer treatment if an accident or serious illness occurs. Under all circumstances, I agree to accept full responsibility for and to pay for the cost of any medical care, transportation and other incidental expenses for any medical treatment or services I receive at Ochsner.

HIPAA Acknowledgement: My signature below indicates I have read and understand information related to HIPAA and my responsibilities while shadowing at Ochsner. I acknowledge that there are civil and criminal penalties for the unauthorized access and/or use of confidential patient information. I will adhere to the guidelines as outlines in the training provided.

_____ _____

Participant Signature **Date**

_____ _____

Printed Name **Phone Number**

**Affiliate" means any legal entity that (i) is owned or controlled by, or, either directly or indirectly, is under common ownership or control with Ochsner Clinic Foundation, or (ii) has entered into a partnership agreement, affiliation agreement, management agreement, joint operating agreement, or other similar type of agreement with Ochsner or an affiliate of Ochsner Clinic Foundation as described in (i) hereof.*

EXHIBIT A
CONFIDENTIALITY STATEMENT AND STATEMENT OF RESPONSIBILITY

CONFIDENTIALITY STATEMENT

I acknowledge my responsibility and agree to keep confidential any and all information regarding Ochsner Health System ("Ochsner") patients and proprietary information of Ochsner. The **HIPAA Privacy Rule** prohibits Ochsner from using or disclosing protected health information (PHI) unless authorized by the patient except in certain circumstances and the **HIPAA Security Rule** and the **HITECH Regulations** require Ochsner to safeguard the Confidentiality, Integrity and Availability of electronic protected health information (ePHI) against unauthorized use or disclosure. I have read the material on both HIPAA Privacy and Security and HITECH and agree to comply with these policies and this confidentiality statement and statement of responsibility. Patient, employee and business information is privileged and confidential and any unauthorized or inappropriate release, use and/or discussion is a serious matter which may result in dismissal from the clinical educational program.

My user ID, and the "Password" I choose are my own individual, personal codes for gaining access to electronically stored information. I will not disclose or share them with any other person. My user ID and Password are the equivalent of my personal signature when performing all computer activities and as such, are legally binding. If I share my User ID and Password, use someone else's user ID &/or Password, access my own medical records or otherwise fail to comply with above mentioned Ochsner's Security Policies, I may be subject to dismissal.

I may not use an Ochsner computer to access my own medical records or the records of my family, friends or co-workers even if ordered to do so by the physician. I will access only the information required in the performance of my clinical education and all information is confidential and to be used only in the performance of my clinical education.
I acknowledge that I have had an opportunity to ask questions regarding all Ochsner privacy and security policies and procedures.

STATEMENT OF RESPONSIBILITY

For and in consideration of the benefit provided in the form of experience in evaluation and treatment of patients at Ochsner, I, on behalf of myself and my heirs, successors and/or assigns do hereby covenant and agree to assume all risks of, and be solely responsible for, any injury or loss sustained by the undersigned while participating in the program at Ochsner unless such injury or loss arises solely out of Ochsner's gross negligence or willful misconduct.

_____	_____
NAME (PLEASE PRINT)	SIGNATURE
_____	_____Job Shadowing___
DATE	PROGRAM