Kettering Health Network
Job Shadowing Packet

Thank you for your interest in job shadowing with our Kettering Health Network healthcare professionals.

Completion of the Job Shadowing Request Form does NOT guarantee that you will be able to job shadow. Departments will make accommodations as patient schedules and staffing permit. Please allow two to three weeks before you receive a response.

Please complete the attached forms and submit to Human Resources at the campus at which you wish to shadow, or directly to the Manager of the department, that you wish to shadow in. If returned to HR, this request will be forwarded to the appropriate department leader for consideration.

For Life.®

Kettering Health Network℠

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Job Shadowing Request

Section I: Contact Information

Name: _____
(Last) (First) (Middle)

Address: _____
(Street)

_____
(City) (State) (Zip)

Email: _____ Phone Number: _____

Emergency Contact: _____ Phone Number: _____

Section II: Job Shadowing Information

Please check the box next to the area you wish to shadow *(choose one)*

- ☐ Radiology
- ☐ Nursing
- ☐ Respiratory Therapy
- ☐ Physical Therapy
- ☐ Athletic Training
- ☐ Physician Office
- ☐ Other _____
- ☐ Surgery
- ☐ Emergency Department
- ☐ Advanced Practice Provider (PA/NP)
- ☐ Occupational Therapy
- ☐ Speech Pathology
- ☐ Business Support Area

Is this a graduation requirement? ☐ Yes ☐ No

Is this a school admission requirement? ☐ Yes ☐ No

Are you a Nursing Student? ☐ Yes ☐ No

Job Shadowing Hours requested: ☐ 4 hours or less ☐ 8 Hours ☐ 12 or more

Availability:	Sun	Mon	Tue	Wed	Thur	Fri	Sat
Time: 8-12	☐	☐	☐	☐	☐	☐	☐
12-4	☐	☐	☐	☐	☐	☐	☐
4-8	☐	☐	☐	☐	☐	☐	☐

School _____ Degree/Major(s): _____

Section III: Insurance and Liability *(Please attach proof of health insurance)*

Provider Name:_____

Policy Holder Name:_____ Policy Number:_____

I agree to perform only those functions assigned to me by qualified personnel as designate by my department observation facilitator. Additionally, I will not hold Kettering Health Network (KHN) for any contracted illness or

personal injuries to me while under this agreement. I will assume financial liability for any emergency or medical care needed in relation to this job shadowing experience.

Initial: _____

Section IV: Confidentiality

As a job shadower of Kettering Health Network (KHN), I agree to observe the privacy rights of the patients and their medical information as regulated by the Federal Health Insurance Portability and Accountability Act of 1996. This means that any individual medical data or information that I may hear, see, or observe is not to be disclosed to any individual outside the intent and purpose of the job shadow visit. The information may be discussed with the people directly involved in conducting the visit. I understand the need for and agree to maintain confidentiality. This means I cannot read the patient's chart, cannot tell others outside the hospital that this person is in the hospital, and cannot tell anyone any information about the patient. Furthermore, I understand that if I disclose patient specific data and information to any unauthorized individual, I may be liable for severe fines and penalties.

Initial: _____

Section V: KHN Policy and Behavior

I, the undersigned individual, understand that I am participating in this job shadowing visit as a volunteer to gain a deeper understanding about careers in the medical field and this visit is a privilege for me. I expect no compensation for this job shadowing experience.

I will conduct my job shadowing activities at Kettering Health Network only under the supervision of the designated Kettering Health Network employee. I will support the philosophy of Kettering Health Network and the department in which the experience is being obtained. .

I agree to support Kettering Health Network's policy of professional appearance. T-shirts, shorts, jeans, capris, sandals, and open toed shoes are not allowed. Each person must be neat, clean and devoid of strong perfumes or body odors. Make-up and nail polish can be used in neutral or moderate shades. Visible tattoos are to be covered.

I agree to conduct my job shadowing activities in a professional manner. I agree to not smoking and not using illegal drugs or alcohol or foul language anywhere on the premises.

I agree to arrive for my job shadowing hours at the scheduled time in the department which the experience is being obtained. I understand that the listed policies and behaviors of the Kettering Health Network must be adhered to or I may be asked to leave and not return for any job shadowing opportunities in the future.

Signature: _____ **Date:** _____

Signature of parent or guardian_____ **Date:** _____
(If visitor is under 18 years)

Printed name of parent or guardian_____

Section VI:

I understand that if I have a known infectious disease, I shall not place myself in areas in which I would jeopardize others in Kettering Health Network. If I become aware that I have or suspect a serious infectious disease, I will notify my Department contact person.

Initial: _____

Job Shadowing/Observation Health Requirement Form

Medical Provider Certification Form

Student Information

Last Name: _____ First Name: _____

Address: _____ Phone: _____

KHN Department you are shadowing in:

_____

Director/Manager of the department:

_____

HEALTHCARE PROVIDER CERTIFICATION

I, _____ certify that, _____

Healthcare Provider (PRINT NAME) *Student Name (PRINT NAME)*

has completed the following immunization/test requirements for observation:

For observation in patient care

□ #1 dose MMR (after first birthday) □ #2 dose MMR
□ **OR** positive measles, mumps, rubella titer
□#1 dose Varivax □#2 dose Varivax □ positive titer
□ **OR,** documentation of varicella or herpes zoster disease
□2-step TB test within the past 12 months
□Chest-x-ray/BAMT results if history of + TB test
□Hepatitis B vaccine if working in exposure prone area-received or declined as per OSHA 29 CFR 1910.1030.
□ Current flu vaccination
(not required April to September)

For observation *not* in patient care

□2-step TB test within the past 12 months
□Chest-x-ray/BAMT results if history of + TB test
□ Current flu vaccination (not required April to September)

Date: _____

Medical Provider Signature and stamp: _____

Human Resources/Department Leader Use Only:

□ Approved □ Declined