Email Application to:
student_education@coxhealth.com or
fax to 417-269-8472

Shadowing/Observation Application

Name____ Age_____________ Today's Date___________________________
Shadower's Name | Minimum age 16

Home Phone_____________________ Cell _______________ Email ____

Home Address ____
Street Address | City | State | zip code

Emergency Contact:

___________________________________ ____________________________ ____________________________________
Full Name | Relationship | Phone

Date(s) & location(s) requesting to shadow: ____
Date | Location

Department and/or provider you are wanting to shadow:

____

How many hours are you requesting to shadow?

____

Do you have any past criminal convictions or current criminal charges pending against you? *Please Explain*

____

All information is true to the best of my knowledge. I understand I am responsible for my observation or tour and CoxHealth is not liable if I should experience any unanticipated injury or disease exposure. ***I understand that typing on the line below constitutes a legal signature confirming that I acknowledge and agree that the above information is accurate and correct.***

If the job shadower is age 16 or 17, a parent or guardian signature is required.

___________________________________ ___________________________________
Parent/ Guardian Signature | Parent/ Guardian Printed Name

____
Parent/ Guardian Contact Phone Number(s)

Job shadower's signature____

On the line below please clearly print the email address you would like to have the approval forms sent:

Email: ____

IMMUNIZATION RECORD

Shadower Name____ Today's date________________________

We are dedicated to protecting you and our patients from infectious disease. **The chart below must be filled out for the listed vaccinations**.

Also, ***documentation of the following immunizations is required*** to begin your shadowing/observation experience. A photocopy of your immunizations record **must be attached** to this form as proof of immunization.

Required Vaccinations- Red Recommended Vaccinations- Black	Date of Vaccination (m/d/yyyy)	Clinic or physician's office where vaccinated
2 Varicella vaccinations, written documentation of disease (Chicken Pox) from a healthcare provider, or laboratory evidence of immunity.	First Vaccination Date Second Vaccination Date	
2 MMR vaccinations or laboratory confirmation of disease of immunity.	First Vaccination Date Second Vaccination Date	
Tdap (Tetanus/Diphtheria/Pertussis)		
Flu Shot (Beginning in the Fall and continuing through current active flu season in Greene County)		
Negative TB skin test, or treatment within the last 12 months. Must include results		

*Your health care provider can fax immunization documentation directly to the Education Center at 417-269-4787.

With a typed signature, the applicant acknowledges medical record forms need to be sent to the Education Center to verify the proof of vaccination.

Applicant Signature:____

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CoxHealth

Springfield, MO

CONFIDENTIALITY & SECURITY AGREEMENT

(Workforce Member)

means employees, volunteers, medical staff and other persons whose conduct, in the performance of work for CoxHealth, is under the direct control of CoxHealth, whether or not they are paid by CoxHealth. This includes full and part-time employees, affiliates, associates, students, volunteers, and staff from third-party entities who provide services to CoxHealth.

CoxHealth collects and maintains personal health information or PHI about our patients. Federal and State regulations on patient privacy and confidentiality limit how health care providers and their workforce members may use and disclose this information. As a workforce member of CoxHealth and its Affiliated Entities, I understand that I may come in contact with medical and business related information, through written or computerized records, computer programs and applications, reports, documents, ledgers, written correspondence and verbal conversations in meetings or around hospital staff. All information that I become aware of is considered CONFIDENTIAL and is not to be shared with anyone other than those authorized. Confidential information, verbal or written, is owned by CoxHealth (including Email) as indicated in this Security Agreement only for work/study related issues. I also understand that I am obligated to maintain the confidentiality of all Patient Safety Work Products (PSWP) such as incident reports, peer review, medical and other sensitive or private information as stated in the Patient Safety and Quality Improvement Act of 2005.
By signing this document, I am agreeing to follow all of the confidentiality and security policies of CoxHealth. I realize that failure to follow these policies may be a violation of state and federal laws governing patient confidentiality and will result in disciplinary action up to and including termination of my employment, educational opportunities or workforce member status and termination of my access to CoxHealth's electronic medical record.

1) I will treat all patient and/or business information that I see, hear, or receive, as confidential and privileged information and I will not access employee personnel information without going through the appropriate channels.

2) I will follow all of the confidentiality and security policies of CoxHealth.

3) I will NOT use CoxHealth's electronic medical records to access medical records of my family, friends, or co-workers. I realize that inappropriate access of medical records will result in disciplinary action up to and including termination of employment/educational opportunities. Workforce members who were given access to the CoxHealth computer systems will have their access immediately terminated.

4) I understand that should I need access to medical information on my family members that I will follow the same process as any other person by filling out an authorization and obtaining copies from the Health Information Management Department.

5) I agree that I will only access and review medical records of CoxHealth for purposes of my employment, educational opportunity or workforce status at CoxHealth.

6) I understand that federal law requires all uses of patient information, including for treatment, be limited to that which is reasonably necessary to accomplish the purpose for which information is

being used.

7) I will NOT use the patient information of CoxHealth for research purposes, without prior approval or the patient's written authorization.

8) If I do use CoxHealth's patient information for research, I will enter the disclosures in the CoxHealth HIPAA Accounting of Disclosures database. I realize that failure to document these disclosures is a violation of federal law and will result in disciplinary action.

9) I understand that I may not disclose patient information to any person or entity other than as necessary to perform my job/educational tasks, and as permitted under CoxHealth's policies and procedures.

10) I understand that any patient or family requests for copies of medical records are to be referred to the Health Information Management Department. No approvals will be granted unless the release is consistent with applicable state and federal law.

11) I understand that CoxHealth's medical records are the property of CoxHealth and I may NOT retain or remove any patient information either in paper or electronic form without the written authorization of the Corporate HIPAA Privacy & Security Officer.

12) Medical records of CoxHealth may not be accessed or reviewed for any purpose not specifically stated in this policy unless CoxHealth receives a signed patient authorization form which authorizes CoxHealth to disclose that patient's medical record to you or unless CoxHealth has provided such records to you for a specific purpose related to the health care operations of CoxHealth.

13) Federal law allows patients to request restrictions on how their medical records may be used and disclosed. I understand that it is my responsibility to adhere to any restrictions that have been placed on a patient's medical records.

14) I understand that I am personally responsible for my sign-on name and password. I understand that my sign-on is the equivalent of my signature and I am responsible for all work done under my sign-on.

15) I will safeguard my computer password and will not post it in a public place, such as the computer monitor or a place where it will be easily lost.

16) I will log off of any computer or applications as soon as I have finished using the computer application.

17) I will NOT allow others to use my personal sign-on and password.

Nor will I attempt to learn another user's sign-on and password.

18) I understand that I am not permitted to use another person's sign-on and password to complete work under their name. Example: electronically signing another person's documentation.

19) I understand that using another person's sign-on and password to access medical information could be considered as accessing data under false pretenses. This can be cause for termination of employment or workforce status and could result in criminal and civil penalties.

20) I understand and agree that I will ensure all email with PHI and sensitive information sent to external email addresses will be sent using Secure Email. Rights to the Secure Email program are granted by my supervisor.

21) If I believe that my sign-on and/or password has been compromised, I will immediately contact the CoxHealth Helpdesk at 269-3153.

22) I understand that a physician does NOT have the authority to authorize any changes to this policy, and cannot authorize me to access patient information that is not directly related to my job or educational opportunities.

23) I understand & agree to the guidelines & responsibilities related to the use of a cellular phone or mobile device for business use as stated in CoxHealth policy.

I have read the information Confidentiality Statement and the Security Agreement. I understand and acknowledge that in the event I breach any provision of this agreement, I will be subject to disciplinary action up to and including termination of employment, educational opportunity and/or workforce member status as well as reporting to any applicable licensing authorities. I also understand that failure to comply with the federal HIPAA regulations could result in civil and/or criminal penalties. ***I understand that typing on the line below constitutes a legal signature confirming that you acknowledge and agree that you have read and understand the above information.***

Name: ____

(Please print)

Signature:____ Date:__________________________

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COXHEALTH
PROGRAM PARTICIPANT WAIVER WARNING

Job shadowing participants understand that participation in the shadowing program may be hazardous and CoxHealth's employees and representatives are not responsible for the consequence of any such hazards. Shadowing program participants understand and agree that CoxHealth is not responsible for and assumes no liability for risks or dangers encountered by participants in the shadowing program, or for any accidents, injuries, or illnesses that may occur as a result of participation in the shadowing program. Participants assume any and all risks, agree that CoxHealth shall not be liable for any loss or damage relating to such risk, and agree to hold CoxHealth, CoxHealth Job Shadowing Program participants and authorized representatives harmless for any claim resulting for any such losses or damages. I agree and covenant not to sue CoxHealth and its authorized representatives relating to or resulting from such risks.

Services of CoxHealth:
CoxHealth only provides an environment which exposes participants of the job shadowing program to a variety of experiences encountered in the day to day risks of the healthcare disciplines of interest to program participants. The authorized representatives of CoxHealth and the job shadowing representatives have no control over risks or dangers associated with participation in the program and are not responsible for any injury, illness, damage, or loss which may be occasioned through participation in the job shadowing program.

Participation representations:
Each job shadowing program participant represents that he or she has reached the age of majority, has read and understood the terms and provisions of the job shadowing program, and agrees to be bound thereby as a condition to participating in the job shadowing program. The parent or legal guardian of a job shadowing program participant who has not reached the age of majority agrees that both the minor and the legal guardian agrees to indemnify and hold CoxHealth, CoxHealth Job Shadowing Program participants, and authorized representatives harmless from any claim by the minor resulting from any loss or injury.

The undersigned has read the preceding, understanding the terms and conditions set forth herein, and agrees to be bound by these terms and provisions. ***I understand that typing on the line below constitutes a legal signature confirming that I acknowledge and agree that I have read and understand the above information.***

DATE: ___________________________________

____

Job shadowing participant address

____

Job shadowing participant phone number and emergency phone number

____ ____

Job shadowing participant name Parent/legal guardian Printed name (only for minors)

____ ____

Job shadowing participant Signature Parent/legal guardian Signature (only for minors)

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CoxHealth Job Shadowing Acknowledgement Sheet

(Initial each item to indicate understanding.)

__________ I understand that this shadowing experience is observation only (only allowed to watch and not touch anything) and if I do anything that is hands-on, I will be sent home immediately.

__________ My application is valid for approximately 90 days, with the exact expiration date listed on the approval packet.

__________ I am responsible for calling a department and scheduling my own shadowing experience.

__________ I am responsible for checking-in online once I have scheduled my shadowing experience.

__________ If I would like to shadow more than 5 days with the same department, I must obtain approval from the Vice President of Human Resources. Please expect a two week waiting period for request to be reviewed.

__________ I understand I may be asked to step out of an area at any time by a patient or CoxHealth Employee.

__________ I will not be on my cell phone during my shadowing experience.

__________ I will bring any additional information my school may require at the time of shadowing so that it may be signed by the approved individual.

__________ Per CoxHealth policy, I will be supervised by a non-relative unless approved by the department's Vice President.

__________ I understand that a completed application must be submitted two weeks prior to the beginning of any scheduled shadowing.

__________ I understand that I do not have permission to shadow until I have received an Approval Packet from the Education Center.

__________ I must present my approval packet to each department I shadow in the CoxHealth System.

__________ I understand that if I violate the CoxHealth job shadowing policy or any rules listed above, my name will be flagged in the CoxHealth system and I will not be allowed to shadow with CoxHealth again.

Name (printed): ______________________________________ Date:________________

Signature: ____