# ST. JOHN PROVIDENCE

# STUDENT SHADOWING PROGRAM

## STUDENT BOOKLET



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***Student Shadow Program Overview***

Dear Student:

 Thank you for your interest in participating in our Student Shadowing program. As a student shadow, you have a responsibility to be professional, to understand basic rules and regulations including emergency and safety procedures, as well as be acquainted with HIPAA and confidentiality guidelines. Therefore, you must review and/or complete the following documents prior to your student shadowing experience:

* Student Shadow Application
* Student Shadow Program Guidelines
* Student Shadow Program Parental Permission Slip (*18 years of age and under*)
* Student Shadow Dress Code
* Release of Liability (\**parent or guardian must complete and sign*)
* Student Guide to Patient Confidentiality
* Confidentiality Agreement (\**parent or guardian must also sign*)

We believe this experience will help you explore the many opportunities offered in the health care industry and learn more about your interests in pursuing a health care career.

 As a student shadow, you will have the opportunity to:

* Experience health care in action;
* Learn about career choices and the requirements to pursue different health care careers;
* Observe health care professionals and get a realistic understanding of a typical work day in your career of choice; and
* Understand more about yourself and your interest in pursuing a health care occupation.

 We look forward to your participation in our Student Shadow program. If you have questions or need further information prior to your visit, please contact the Student Shadow Program Coordinator directly. Thank you for your interest in choosing a career in health care.

**STUDENT SHADOW APPLICATION**

|  |
| --- |
| ***Personal Information*** |
| Name: |
| Street Address: |
| City/State/Zip Code: |
| Home phone ( ) | Other phone ( ) |
| E-mail address |
| Are you 18 years of age or older? \_\_Yes \_\_No | Date of Birth (month/date/year) |
| \_\_\_\_ College Student \_\_\_\_ High School Student \_\_\_ Other (specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) |
| Have you ever been convicted of a crime? Misdemeanor? \_\_\_ No \_\_\_ Yes  Felony? \_\_\_ No \_\_\_ Yes |
| ***Emergency Contact Information*** |
| Name:  | Relationship |
| Home phone ( ) | Other phone ( ) |
| Street Address |
| City/State/Zip Code |
| ***References (two non-family members)*** |
| Name | Relationship |
| Street Address |
| City/State/Zip Code |
| Daytime Phone ( ) |
|  |
| Name | Relationship |
| Street Address |
| City/State/Zip Code |
| Daytime Phone ( ) |
| ***School Information*** |
| School Name: Current Grade/Year: |
| Counselor's Name Phone ( ) |

I hereby certify that the responses on this document are true to the best of my knowledge. I understand that false statements or omissions may be grounds to reject my application or for dismissal from volunteering. I agree that this information may be verified and references contacted.

I further understand that by my signature I authorize St. John Providence ("SJP") to conduct a background check and that my shadowing is contingent upon the satisfactory completion of a tuberculosis test and background check.

I authorize SJP to release all records or other information pertaining to any disciplinary action taken against me during my shadowing. I hereby release SJP and its agents and associates from any liability whatsoever resulting from the release of such records or information.

I clearly understand that there is no employer/employee relationship and as a service volunteer, I will not be entitled to compensation or fringe benefits of any kind for voluntary service.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

**STUDENT SHADOW PROGRAM GUIDELINES**

***AGE LIMITS***

The Student Shadow Program is limited to High School and Post-Secondary Students. This age requirement is in place to ensure that students understand the appropriate rules and regulations and act accordingly.

***STUDENT CONDUCT***

You are a guest of the health care facility. As a guest, you are expected to act professionally and respectfully at all times. Failure to do so will result in immediate termination of your student shadowing experience.

***SICKNESS, TARDINESS AND ABSENCE***

If you are sick, tardy or going to be absent, you must contact the Student Shadow Program Coordinator that you’re assigned to for that day.

***CONFIDENTIALITY***

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") regulations require that all patient information be properly protected. All students must read and understand the Student Guide to Patient Confidentiality and sign a Confidentiality Statement prior to participating in the program.

**STUDENT SHADOW AGREEMENT**

**AND RELEASE OF LIABILITY**

To be reviewed and completed by Student (and Parent or Guardian of Student if Student is under 18 years of age):

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, ("Student") agree to abide by all Student Shadow Program Guidelines, applicable laws and regulations, and St. John Providence and its affiliated health care organizations ("Hospital") policies governing patient confidentiality and any other applicable Hospital policies. I agree that patients in the Hospital have a right to privacy and may decline to give consent for me to observe patients. I agree not to reveal any information concerning inpatients or outpatients unless such disclosure is necessary for the patient's treatment. If I divulge confidential information for any other reason, I will immediately forfeit my opportunity to participate in the Student Shadow Program with the Hospital and shall immediately be dismissed from the Student Shadow Program. If I breach any Student Shadow Program Guidelines, any applicable laws and regulations, any Hospital policy, or disclose confidential information, I shall be immediately dismissed from the Student Shadow Program and shall not be eligible to participate for three (3) years from the date of breach.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Student Signature

Parental Permission. I grant permission for my child, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, to participate in the Student Shadow Program offered through Hospital based upon the terms and conditions above and those terms and conditions incorporated in the Student Shadowing Program Booklet. I agree to hold Hospital or any of its directors, officers, employees or agents, harmless in the event of an incident, injury or illness. I further state that I am the parent or legal guardian of my child, I am of lawful age, and I am competent to sign this Release of Liability form. I have read the above conditions and fully understand the consequences of signing this document.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Parent /Guardian Signature

**STUDENT SHADOW DRESS CODE**

Student Shadows are expected to look and act professionally. Proper attire for your student shadowing experience is important. Failure to adhere to the following dress code may result in termination of your student shadowing experience.

***DRESS CODE GUIDELINES***

* Dress in a professional manner.
* Dress modestly and neatly with shirt tucked into pants.
* Do not dress to extremes (too dressy, too trendy, too much jewelry, etc.).
* Do not wear clothing that portrays suggestive or derogatory pictures and messages, including advertising of alcohol, tobacco, etc.
* No sleeveless blouses, shirts or tops.
* No short skirts (skirts or skirt slits must be no shorter than three inches above the middle of the knee).
* No tight or revealing clothing.
* No jeans or sweatpants.
* No bare midriffs (short or cropped shirts).
* Wear clean, flat, comfortable walking shoes-- no sandals or open-toed shoes.
* No visible body piercing (nose, eyebrow, tongue, lip and body jewelry).
* Clothing should cover all undergarments.
* Be neat and clean.
* Hair should be secured away from face. Men's hair longer than shoulder length must be confined in a neat manner. Beards, sideburns, and mustaches must be neatly trimmed.
* No excessive perfumes or heavy scents.
* No excessive make-up.
* Any tattoo that could be considered offensive to others must be covered.

The Student Shadowing Coordinator is responsible for evaluating the dress and appearance of all students. If a student is not dressed appropriately, the student's parent or guardian will be contacted to bring appropriate attire and/or the student shadowing experience will be terminated.

**STUDENT GUIDE TO PATIENT CONFIDENTIALITY**



Under federal and state law, health care providers are required to protect the confidentiality of a patient's health information ("PHI") and ensure that patient-identifying information is only disclosed when essential to the care and treatment of the patient. Therefore, it is important for students to understand patient confidentiality requirements and agree to abide by the policies and guidelines of the hospital prior to beginning a student shadowing experience.

Each student chosen to participate in a Student Shadowing Experience at St. John Providence ("SJP") is required to read the following student guide to patient confidentiality and acknowledge his/her understanding by signing a Confidentiality Agreement.

**WHAT IS HIPAA?**



HIPAA stands for the Health Insurance Portability and Accountability Act of 1996. HIPAA is a federal law that health professionals follow to keep a patient's medical information confidential. It is over 1,500 pages of federal rules and regulations that announce requirements that relate to the confidentiality of "protected health information." The laws apply to any organization and business that provides health care services or exchanges patient health data. HIPAA covers all hospitals, doctor's offices and pharmacies. Understanding and complying with HIPAA is very important. Institutions and individuals who break the law can be required to pay monetary damages and could be criminally charged.

**WHAT INFORMATION IS CONFIDENTIAL?**



Confidentiality is keeping information secret. PHI is information that hospitals and health care Providers must keep confidential under HIPAA. PHI is most often found in a patient's health record. A hospital or health care provider may use or disclose PHI:

* For its own treatment, payment or health care operations;
* To another health care provider for treatment activities;
* To another covered entity (health plan, another health care provider, or clearinghouse) for the recipient's payment activities;
* To another covered entity for its health care operations under certain conditions; and
* To its business associates.

PHI can exist in any form including:

* Oral (phone conversations)
* Written (medical record)
* Electronic (patient database)

**PHI IS ANYTHING THAT CAN IDENTIFY A PERSON AS AN INDIVIDUAL.**

Some examples of PHI include:

* Name
* Address, city, county, zip
* Birthdate
* Phone/fax numbers
* Email address
* Social Security number
* Medical record number
* Admission date

Use and Disclosure of PHI

Use means the internal access, utilization, and sharing of PHI. Disclosure means the release, transfer, access, or divulging of PHI to a person outside the hospital or health care facility.

As a student shadow, HIPAA affects you. By law, you are required to keep a patient's information confidential. During your student shadowing experience you are expected to keep any and all information you learn about a patient confidential. Failure to do so will result in immediate termination of your student shadowing experience and could result in more severe consequences.

**Students should NOT**:



* Students should not access or use PHI unless you have a legitimate work reason for doing so and have been directed by your supervisor.
* Students should not give PHI to anyone outside or inside of the hospital or health care facility.
* Students should not talk about patients or a patient’s PHI to anyone when discussing their student shadowing experience.

***DO NOT DISCUSS PATIENT INFORMATION WITH ANYONE-- EVEN A PATIENT.***

**CONSEQUENCES FOR VIOLATING HIPAA**



The hospital or health care facility you are shadowing in is required to comply with the requirements of HIPAA and maintain patient confidentiality. As a student shadow, you are required by law to keep a patient's information confidential. There are NO exceptions.

***Remember, being a student shadow is a fun and rewarding experience. Please keep patient information confidential and be respectful of patient rights. Most importantly, you cannot share patient information with anyone. To do so can have serious consequences and at a minimum, will result in your immediate termination of your student shadowing experience.***

**STUDENT SHADOW CONFIDENTIALITY AGREEMENT**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, will be participating in a Student Shadowing Program with St. John Providence for the educational purpose of exploring my interest in health care. I understand that I may view, hear and/or otherwise have access to confidential patient protected health information ("PHI"), healthcare information and other privileged documents. As such, I understand that I must review and adhere to the requirements of the Health Insurance Portability and Accountability Act ("HIPAA") as outlined in the *Student Guide To Patient Confidentiality*. I recognize that failing to adhere to HIPAA will result in the immediate termination of my Student Shadowing experience and may have additional consequences.

By signing below, I represent that I have read the *Student Guide To Patient Confidentiality* and understand that I am obligated to maintain the protection of patient privacy and other confidential matters. I understand that any confidential or privileged information that I may see, hear, or otherwise access cannot be disclosed during or after my student shadowing experience.

I hereby certify that I have read this document and am aware of the confidentiality requirements expected of me.

**Name** (print or type)

**Signature Date**

**Name of Parent or Guardian if Student is under 18 years of age** (print or type)

**Signature of Parent or Guardian Date**

**STUDENT RESPONSIBILITIES ACKNOWLEDGEMENT**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, a student at \_\_\_\_\_\_\_\_\_\_\_\_\_ ("School") desire the opportunity to obtain observation experience through participation in a shadowing program ("Shadowing Experience") at St. John Providence ("SJP").

1. My Shadowing Experience shall consist of approximately \_\_\_ hours on \_\_\_\_\_\_\_\_\_\_, 20\_\_ as mutually agreed with SJP.
2. I understand and agree that my Shadowing Experience will be strictly limited to only the observation of patient care under the supervision of SJP staff and only with the prior documented consent of the patient. I further understand and agree that SJP patients may refuse to allow observation by me at any time.
3. I understand that I will at no time be allowed to give patient care, touch patients or instruments, or make entries into the patient chart or any other SJP document. I understand that my role is to observe patient care and/or procedure(s), and at no time may I participate in any patient care or procedure(s) observed. I understand that I may experience physical and emotional reactions to the observation experience, which could cause me to experience physical and/or emotional injury. I hereby agree to release, indemnify and hold harmless SJP, its medical staff members, employees and agents from all liability related to my observation experience.
4. I understand that, in participating in the Shadowing Experience, I will be exposed to the normal risks of any SJP visitor, as well as possible additional risks that arise because I will be in patient care areas and observing patient care.
5. I understand and agree to abide by: (i) all applicable SJP policies and procedures, including, without limitation, personnel policies and procedures of SJP, and those policies and procedures relating to safety, patient care and non-discrimination, (ii) the requirements of the Michigan Department of Community Health, The Joint Commission and other applicable federal, state, county agency, and/or accreditation bodies, and (iii) infection control standards, safety standards, confidentiality standards, and Occupational Safety and Health Administration ("OSHA") requirements. I further understand and agree that failure to do so may result in the immediate termination of my participation in the aforementioned Shadowing Experience.
6. I understand and agree that I shall not use or disclose to any third party any trade secrets and/or confidential information, facts or documents relating in any way to SJP's business operations, patients, suppliers, vendors, personnel, contracts or financial condition or any other confidential or proprietary information except as necessary for the completion of my Shadowing Experience. I understand the foregoing does not apply to publicly available information or information required by court order or applicable law.
7. I agree that I will not access, release, or share Protected Health Information (“PHI”) as defined under HIPAA. I further understand that I may not access any information on my friends or family members and may not release any information to anyone other than SJP employees, agents, etc. who have a need for such information.
8. I agree that when my Shadowing Experience with SJP ends, I will not take any PHI with me and will not reveal any PHI that I had access to as a result of my duties at SJP.
9. I understand and agree that I am not, and will not be, an employee of SJP and will therefore will not be eligible for any of the compensation or benefits that SJP's employees receive.
10. I authorize all necessary exchanges of information between SJP and School related to me and my participation in the Shadowing Experience.
11. I agree to clearly identify myself as a student, both visually by the wearing of a name badge and in all written and verbal communication, to all patients, providers, and staff during my Shadowing Experience. I will return the name badge to SJP at the end of the Shadowing Experience if so requested.
12. I agree to act only within the scope of my Shadowing Experience and, at such times as are necessary, will immediately attempt to resolve any question or doubt I have as to the extent of that scope with the appropriate SJP supervisor.
13. I have been appropriately immunized and agree to submit to any additional health examinations that might be necessary to my participation in the Shadowing Experience and further agree to make the results of any such additional examinations available to SJP upon request.
14. I understand that SJP may make emergency care available to me during the term of my Shadowing Experience and that such emergency care will not be given without charge. I agree that I will be financially responsible for any medical care provided by SJP, including any emergency care.
15. I understand and agree that SJP retains the right to remove me at any time, if SJP deems such removal to be in the best interests of SJP and its patients.
16. I agree to release SJP from any liability for the loss of or damage to my personal property while on SJP property. I also hereby agree that I will indemnify and hold SJP harmless against any and all claims or liabilities, including any negligence claims, for damages that I cause to patients and/or SJP, or its agents or representatives, in any way arising from or relating to the Shadowing Experience. By signing this Student Responsibilities Acknowledgement, I, and my parent or guardian if applicable, acknowledge that I understand the dangers of participating in the Shadowing Experience and hereby release SJP, its administration, Board of Directors, employees and agents from any and all liability from my participating in the Shadowing Experience. I hereby agree that I will not sue SJP and I will release SJP from any claims I may have against it except for gross negligence or reckless or willful misconduct on the part of SJP, its trustees, officers, agents, and employees. I agree that this Student Responsibilities Acknowledgement shall be binding and of full force and effect upon my heirs, assigns, executors, personal representatives, and guardians, including parents, durable powers of attorney or next of kin.
17. I certify that I have no known physical or mental illness or condition, including any contagious disease, which could be detrimental to the welfare or interfere with the care of any of SJP’s patients or staff. I certify that I am currently covered by health care insurance or Medicare/Medicaid and that it shall remain in effect through the end of my participation in the Shadowing Experience.
18. I understand that SJP does not view this Shadowing Experience as subject to the Family Educational Rights and Privacy Act (“FERPA”) and I will be given no confidentiality considerations under FERPA.
19. I agree to wear appropriate attire for this Shadowing Experience, as outlined in the Student Shadow Dress Code. I will not be permitted to remain at SJP unless dressed appropriately.

STUDENT:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name Program

PARENT/GUARDIAN (If student is under 18 years of age): I hereby agree to the above terms on behalf of the above-named student.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name Program