

APPLICATION FOR JOB SHADOWING

To be eligible for Job Shadowing, you must be 16 years old or older and you will be required to submit the following:

- Proof of immunization history including MMR, TDAP, Hepatitis B, and Varicella.
- Proof of TB test with negative result given within the last 12 months – must be a two-step TB skin test, QuantiFERON gold, or a T-Spot lab test
- Proof of seasonal flu vaccination or declination (required for observations taking place between Sept. 1 and March 31)

Name _____

Address _____

City, State, Zip _____

Phone _____

Email _____

Are you 18 years old or older? _____ Date of Birth _____

**** Parent/Guardian permission is required for students younger than age 18**

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name _____

Address _____

City, State, Zip _____

Phone _____

Relationship: _____

Educational Institution: _____

APPLICATION FOR JOB SHADOWING

Educational Institution Address: _____

Educational Institution Contact/Phone: _____

What department or individual would you like to shadow? (Ex: Acute Care,
Emergency Department, Radiology, Laboratory, Clinic, etc...)

Please describe your learning objective and plans for applying the knowledge you may obtain.

Please provide the dates/times for which you are requesting to shadow. *Please allow a
minimum of 2 weeks before your job shadowing request.*

For HR Department Use Only

Job Shadowing Request: Approved _____ Denied _____

Date Applicant Notified: _____ - - - -

Dept./Staff Member to Shadow: _____ - - - -

Dates of Job Shadowing: _____

Job Shadowing Orientation: _____

JOB SHADOWING GUIDELINES

Job shadowing can provide experiences that are as unique as every person who participates. Reaching any career goal takes personal commitment. Every plan for tomorrow requires action today. Even if you have no idea what career is right for you, it is possible to begin preparing for the world of work.

Job shadowing is an observation experience that provides an opportunity for participants to learn about healthcare careers, everyday routines of healthcare workers and the skills required. The participant will have an opportunity to observe and interact with a healthcare worker as they go about their daily activities. Hands on patient care isn't part of the job shadow experience and will not be permitted. The purpose of the job shadow experience is to foster an awareness of the skills required for a specific career and to experience healthcare culture.

Guidelines for Participants

- Participants must be 16 years or older.
- Participants can be High School Students, College Students, Employees, Volunteers, or Individuals interested in a second career.
- Participants must submit the required immunization and TB records.
- Participants must sign a confidentiality statement agreeing not to discuss patient information outside of Fairfield Memorial Hospital.
- Participants must complete Orientation of Roles and Responsibilities of the Student and Infection Prevention.
- Participants must conduct themselves in a respectful manner.

Attire

Dress in a professional manner when completing a Job Shadow experience. Business casual attire is appropriate.

- Clothing must be clean and fit properly. Upper and lower torso must be covered; no skin should show when arms are raised above your head or when you bend over. Cleavage should not be visible.
- Socks or hose must be worn with closed-toed shoes, which must be clean.
- Facial piercings are not permitted to be visible.
- Only natural shades of hair color are permitted. Colors such as purple, pink, green, blue, yellow, etc are not allowed.
- **Do not** wear the following: denim jeans, tee shirts, cut-offs, low-cut tops, hooded sweatshirts, open-toed shoes, tank tops, half-shirts, shorts, hats, or baseball caps. Jewelry should be kept to a minimum. Perfume or cologne should not be worn in patient care areas.

Fairfield Memorial Hospital reserves the right to refuse or send home anyone who does not uphold these standards.

APPLICATION FOR JOB SHADOWING

PATIENT PRIVACY AND CONFIDENTIALITY

At Fairfield Memorial Hospital, our patients and their families are at the center of all that we do. We recognize that our actions and behaviors impact our patients, so we strive to provide excellence in every patient interaction. All positions within FMH adhere to this philosophy.

- Patients and Families are the center of all that we do. They are the only reason we are here and why you are able to have this experience.
- You will have the opportunity to interact with patients, families, and many staff members.
- Your facial expressions, speech, the way you interact, and how you present yourself all have an effect on the Patient's Experience, whether you know it or not.
- Keep all information pertinent to the experience confidential, including things you may have seen or heard, as outlined in the Student Confidentiality Statement. This statement is part of the Job Shadowing application and must be reviewed and signed.
- A patient may want to protect their privacy by declining a request to have you shadow. It is the patient's right to do so. In this case, you will politely excuse yourself and wait where the preceptor asks you to while care is provided to the patient.

HIPAA – What you need to know:

- HIPAA is a federal privacy law that the hospital staff follows to keep a patient's medical information confidential. It affects each staff member at the hospital as well as the volunteers and visitors.
- HIPAA stands for Health Insurance Portability and Accountability Act and it became law in August 1996.
- While you are here shadowing, these regulations apply to you too.

What you need to understand:

- This means the staff at the hospital has a legal duty to protect a patient's privacy.
- It is a patient's right to be treated confidentially in a hospital.
- It is also very important that a patient knows that their privacy is protected.
 - If a patient feels that they cannot trust us with their information, they may withhold important information for fear of it getting exposed.
 - If a patient withholds this information, a doctor will not have all the information he or she may need to correctly diagnose the patient.
- **DO NOT discuss patient information with anyone.**

This is a policy that applies to everyone.

- Everyone who works at the hospital or clinic knows the importance of the confidentiality of patients. Even the staff who do not regularly interact with patients understand that if they do obtain information for whatever reason, it is to be kept confidential.
- It is sometimes difficult to understand that you may learn information that you cannot even tell your mom, dad, or best friend about. But it is extremely important that you understand and comply with these policies in order to be a part of the Job Shadowing program

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CONSENT TO PARTICIPATE

I, the undersigned, for and in consideration of the benefit to be derived by the participation of the career observations, do hereby release and forever discharge Fairfield Memorial Hospital, it's agents, servants, representatives and staff from and against any and all liability and responsibility for any injury, illness or sickness which may result from the participation in the career observation, and do hereby further agree to indemnify and hold harmless Fairfield Memorial Hospital, it's agents, servants, representatives and staff, from any and all liability in such regard.

I acknowledge that Fairfield Memorial Hospital has granted me permission to observe certain aspects of healthcare at one or more of its facilities. I hereby acknowledge that in so observing, I am merely a bystander with no responsibilities for caregiving, and that my status at the facility is that of a non-participant in the delivery of health care services.

Parent signature is required if participant is under the age of 18 years old.

HIPAA and CONFIDENTIALITY STATEMENT

1. Health Insurance Portability and Accountability Act (HIPAA) – The HIPAA Privacy Rule ensures privacy and confidentiality of patient information by limiting the ways health plans, pharmacies, hospitals, and other covered entities can use a patient's protected health information. These regulations protect medical records and other individually identifiable health information, whether it's on paper, in computers or communicated orally. HIPAA gives patients control over their health information because it established a list of rights afforded to them in relation to their protected health information. You may not access your own patient information or that of friends or relatives. You may not share information you learn as a result of this career observation with others (ie. church members, family, friends, or the media) who are not part of the patient's care. Treat patient information as you would want your own information treated.
2. Confidentiality and Security – I understand that information concerning patients, their illness or their families is confidential. I preserve this right to confidentiality by not discussing this information in public settings or with individuals not required to have access to this information based upon law and job functions. I understand that I do not have the right to access my own or family members' medical information.

I understand that Fairfield Memorial Hospital is not held responsible for any accident or injury that may occur on its premises while shadowing. In addition, I am to leave valuables at home and realize it is my responsibility that these items are secured prior to shadowing.

Participant's Signature

Date

Parent/Guardian Signature

Date

BACKGROUND CHECK ACKNOWLEDGEMENT AND AUTHORIZATION

By signing this Background Check Acknowledgement and Authorization form, I hereby authorize Fairfield Memorial Hospital to contact any and all corporation, former employers, educational institutions, law enforcement agencies, city, state, county, and federal courts, military services to release information about my background including, but not limited to, information about employment, education, driving record, criminal record, and general public records history to Fairfield Memorial Hospital.

I hereby authorize any and all schools, former employers, references, courts and any others who have information about me to provide such information to Fairfield Memorial Hospital and/or any of its representatives, agents or vendors and I release all parties involved from any and all liability for any and all damage that may result from providing such information.

I further acknowledge that Fairfield Memorial Hospital shall not be liable for the failure to hire or retain me as an applicant, student, employee, or volunteer if I have been convicted of committing or attempting to commit one or more of the offenses stated in the Health Care Worker Background Check Act (225 ILCS 46/25).

I understand that any false or deliberate omissions on this document may be grounds for disqualifications from employment, training, or volunteering, if discovered after employment, training, or volunteering begins, and can result in discipline up to and including my termination of employment, being a volunteer or a student.

I understand that the information requested below is for the sole purpose of identification and the accurate gathering of the criminal history record information, and that it will not be used to discriminate against me in violation of the law. I understand that the provision of my Social Security number is required by law. A facsimile or photographic copy of this Authorization will be as valid as the original.

By signing this document, I acknowledge that I have received a copy of "A Summary of Your Rights Under the Fair Credit Reporting Act."

BY SIGNING BELOW I ACKNOWLEDGE THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ABOVE STATEMENTS.

Name: _____

(Please Print) Last Name First Name Middle

☐ Female ☐ Male

Address: _____

City/State/Zip: _____

Date received degree (if applicable): _____

Social Security Number: _____ Date of Birth: _____

Driver's License Number and State: _____

Signature of Applicant/Student/Volunteer

Date

Statement of Understanding of and Compliance with the Facility's Compliance Program

I certify that I have received, read, and understand the Corporate Compliance Program, the Code of Conduct, and the Medicare Learning Network – Medicare Part C & D Compliance Training. I agree to comply with all requirements, standards, and expectations described in these documents throughout my employment or service with Fairfield Memorial Hospital Association (FMH).

I acknowledge and agree to the following:

1. Duty to Comply

I understand that I am responsible for knowing and following all FMH policies, procedures, compliance standards, and applicable federal and state laws and regulations governing my role. Compliance is a condition of employment.

2. Duty to Report

I have an ongoing obligation to promptly report any actual, alleged, or suspected violation of:

- The Corporate Compliance Program
- The Code of Conduct
- FMH policies or procedures
- Federal or state laws or regulations
- Fraud, waste, or abuse
- Patient safety or quality concerns

Reports may be made to my supervisor, the Compliance Officer, or through any approved reporting mechanism. FMH strictly prohibits retaliation for good-faith reporting.

3. Duty to Cooperate

I agree to fully cooperate in any compliance investigation, audit, review, or inquiry conducted by FMH, regulatory agencies, or authorized third parties.

4. Eligibility to Participate in Federal and State Programs

I certify that:

- I have not been convicted of, charged with, or investigated for a criminal offense related to healthcare.
- I am not excluded, suspended, debarred, or otherwise ineligible to participate in any federally or state-funded healthcare program.
- I will immediately notify the Compliance Officer if my eligibility status changes or if I become aware of any circumstance that may affect my ability to participate in such programs.

5. Confidentiality and Protection of Information

I understand that I am responsible for safeguarding all patient, employee, business, and proprietary information in accordance with HIPAA, FMH policies, and all applicable laws. Improper access, use, or disclosure of confidential information is a violation of the Compliance Program and may result in disciplinary action.

6. Consequences of Non-Compliance

I understand that violations of the Compliance Program, Code of Conduct, or any FMH policy may result in disciplinary action, up to and including termination of employment or assignment, and may also result in civil or criminal penalties.

7. Post-Employment Obligations

I understand that my duty to maintain confidentiality and my obligation to report known or suspected compliance violations continue after my employment or service ends.

Disclosure Section

I understand that I must disclose any circumstance that may present a compliance, legal, ethical, or regulatory concern. This includes, but is not limited to:

- Any past or current investigations, sanctions, exclusions, disciplinary actions, or licensure restrictions.
- Any pending or resolved criminal charges, civil actions, or administrative proceedings related to healthcare, fraud, dishonesty, violence, or professional conduct.
- Any financial, personal, or business relationships that could create a conflict of interest or the appearance of one.
- Any outside employment, consulting, or contractual arrangements that involve healthcare services, billing, or referral relationships.
- Any known or suspected violation of FMH policies, the Code of Conduct, or applicable laws or regulations.

Disclosure (attach additional pages if needed):

☐ **I have no disclosures to report at this time.**

I understand that failure to disclose relevant information may result in disciplinary action, up to and including termination, and may also result in reporting to regulatory or licensing authorities. I agree to promptly update this disclosure if circumstances change.

Please check one:

- ☐ **Initial Review** – This is my first review of the Compliance Program and Medicare Part C & D Compliance Training.

☐ **Annual Review** – This is my annual review of the Compliance Program and Medicare Part C & D Compliance Training.

Employee Name (Print): _____

Employee Signature: _____

Date: _____

HR Representative: _____

Date: _____

Confidentiality Statement

All employees, volunteers, students, interns, consultants, and contracted personnel of Fairfield Memorial Hospital (FMH) have a strict legal and ethical obligation to maintain the confidentiality, privacy, and security of all patient information. This obligation applies to any information related to a patient's care, treatment, services, billing, or identity—whether obtained during a hospital stay, outpatient visit, or through any FMH system or communication channel.

Confidentiality must be maintained in accordance with all applicable federal and state laws, including the Health Insurance Portability and Accountability Act (HIPAA), the HITECH Act, the HIPAA Omnibus Rule, and all FMH policies and procedures. This duty applies to information in any form, including verbal, written, printed, electronic, photographic, or digital formats.

I understand and agree to the following:

- I will only access the minimum necessary information required to perform my assigned job duties.
- I will not access my own medical record or the record of a family member, coworker, or any other individual unless required for my job duties and authorized by FMH policy.
- I will not share, discuss, disclose, copy, photograph, or remove patient information except as permitted by law and FMH policy.
- I will protect patient information from unauthorized viewing, including on computer screens, mobile devices, and printed materials.
- I will not discuss patient information in public or unsecured areas, including hallways, elevators, cafeterias, or social media.
- I will immediately report any suspected or actual privacy or security breach to my supervisor or the Compliance/Quality Department.
- I understand that FMH monitors access to electronic systems and that inappropriate access will be detected through audit logs.
- My obligation to maintain confidentiality continues after my employment or assignment ends, regardless of the reason for separation.

I understand that any unauthorized access, use, or disclosure of patient information—whether intentional or accidental—may result in disciplinary action up to and including immediate termination of employment or assignment, and may also subject me to civil and/or criminal penalties under federal and state law.

By signing below, I acknowledge that I have read, understand, and agree to comply with this Confidentiality Statement.

Contractor Name (Print): _____

Contractor Signature: _____

Date: _____

HIPAA Privacy, Security, and PHI Access Acknowledgment

Fairfield Memorial Hospital (FMH) is committed to protecting the privacy and security of all Protected Health Information (PHI) in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the HITECH Act, the HIPAA Omnibus Rule, and all applicable federal and state privacy laws.

By signing this acknowledgment, I confirm that I understand my responsibilities regarding the access, use, disclosure, and safeguarding of PHI in all forms—verbal, written, and electronic.

1. Definition of Protected Health Information (PHI)

I understand that PHI includes any individually identifiable health information related to a patient's past, present, or future physical or mental health, healthcare, or payment for healthcare. PHI includes, but is not limited to:

- Name, address, phone number, email
- Dates of birth, admission, discharge, or service
- Medical record numbers
- Social Security numbers
- Insurance information
- Diagnoses, test results, treatment information
- Photographs, videos, or biometric identifiers

PHI may exist in any format: verbal, written, electronic, digital, photographic, or otherwise.

2. Minimum Necessary Standard

I understand that:

- I may only access the minimum amount of PHI necessary to perform my assigned job duties.
- I may not access PHI "out of curiosity," personal interest, or for any reason unrelated to my job.
- I may not access PHI belonging to coworkers, friends, family members, or myself unless required for my job duties.
- If I need access to my own medical record, I must request it through the Health Information Department or patient portal.

Unauthorized access is considered snooping and is a major HIPAA violation.

3. Prohibited Access and Use

I understand that I am strictly prohibited from:

- Accessing my own medical record through the EHR
- Accessing the medical record of a family member, coworker, or acquaintance
- Asking another employee to access PHI on my behalf
- Sharing, copying, photographing, or removing PHI without authorization

- Accessing PHI for personal, educational, or non-work purposes
- Using PHI in personal conversations, social media, or messaging apps
- Discussing PHI in public or unsecured areas

Unauthorized access or disclosure may result in disciplinary action up to and including termination, and may also result in civil or criminal penalties.

4. Confidentiality Obligations

I understand that:

- PHI must be kept confidential at all times.
- My confidentiality obligations continue after my employment ends, regardless of the reason for separation.
- I must take reasonable steps to prevent unauthorized viewing of PHI, including:
 - Positioning screens away from public view
 - Minimizing screens when visitors or unauthorized individuals are present
 - Securing documents and devices
 - Avoiding conversations about PHI in public areas

5. Electronic Systems, EHR Access, and Audit Monitoring

I understand that:

- All access to FMH electronic systems is monitored and audited.
- My login credentials uniquely identify me, and I am responsible for all activity performed under my username.
- I must not share my password or allow anyone else to use my login.
- I must log out or lock my workstation when leaving it unattended.
- Attempts to access PHI without authorization will be detected through audit logs.

6. Mobile Devices, Texting, and Electronic Communication

I understand that:

- PHI may not be transmitted through unsecure text messaging, personal email, or social media.
- PHI may not be stored on personal devices unless explicitly approved and encrypted.
- Photos, screenshots, or recordings of patients or medical records are prohibited unless authorized for clinical purposes.

7. Social Media Restrictions

I understand that:

- I may not post, share, or discuss any patient information on social media—even if the patient is not named.
- “De-identified” information may still violate HIPAA if the patient could reasonably be recognized.
- I may not post photos taken inside patient care areas unless approved by Administration.

8. Breach Reporting Requirements

I understand that:

- I must immediately report any suspected or actual privacy or security breach to my supervisor, Compliance/Quality, or Administration.
- A breach includes:
 - Viewing PHI without authorization
 - Sharing PHI improperly
 - Losing documents or devices containing PHI
 - Sending PHI to the wrong recipient
 - Any unauthorized access, use, or disclosure

FMH is legally required to notify affected individuals of breaches, and I am required to cooperate fully in any investigation.

9. Consequences of Violations

I understand that violations of HIPAA or FMH privacy policies may result in:

- Disciplinary action up to and including termination
- Civil penalties
- Criminal penalties
- Mandatory reporting to licensing boards
- Personal liability in certain circumstances

10. Acknowledgment

By signing below, I acknowledge that:

- I have read and understand this HIPAA Privacy, Security, and PHI Access Acknowledgment.
- I agree to comply with all FMH policies, procedures, and legal requirements regarding PHI.
- I understand that failure to comply may result in disciplinary action, termination, and legal consequences.
- I understand that my obligations continue after my employment ends.

Employee Name (Print): _____

Employee Signature: _____

Date: _____

HR Representative: _____

Date: _____