Job Shadowing/Observation Request Form

Thank you for your interest in observing healthcare professionals at Mitchell County Hospital Health Systems! We hope that your experience within our facility will help you in determining your educational and career path.

Completion of the Shadowing and Observation Request Form does not guarantee that you will be able to observe. Departments will make accommodations as patient schedules and staffing permit.

Please allow up to two weeks before your planned shadowing date. You will be contacted by the department manager/director you are requesting to shadow.

Please complete the attached form and submit it to Human Resources with the required documents.

Submit Forms To:

Mitchell County Hospital Health Systems
Attn: Human Resources
P.O. Box 399
Beloit, KS 67420

Sincerely,

MCHHS Human Resources Department

MCHHS
MITCHELL COUNTY HOSPITAL
• HEALTH SYSTEMS •

SHADOWING AND OBSERVATION REQUEST FORM

Section I: Contact Information

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

Address: _____
(Street)

_____
(City) (State) (Zip)

Email: _____ Phone Number: _____

Emergency Contact: _____ Phone Number: _____

Section II: Education Information

High School: _____ Grade: _____

College: _____ Graduation Date: _____

Degree/Major(s): _____

Section III: Observation Information

Department and/or Specialty *(example: Emergency Nurses)* _____

Number of Hours _____ Date(s) *please specify*: _____

Reason for Request: *(Attach additional paper as needed)*

_____

_____

_____

_____

Section IV: Liability

I understand this is an observational experience and agree to perform only those functions assigned to me by a qualified personnel as designated by my department observation facilitator. Additionally, I will not hold Mitchell County Hospital Health Systems (MCHHS) liable 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 observational experience.

Initial: _____

Section V: Confidentiality

As an observer of Mitchell County Hospital Health Systems (MCHHS), 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 my observational experience. The information may be discussed with people directly involved in conducting the observational experience. I understand the need for and agree to maintain confidentiality. This means I cannot read the patient's chart, cannot tell others outside of the hospital that this person is in the hospital, and cannot tell anyone any information about the patient. I further understand that if I do disclose patient specific data and information to any unauthorized individual, I may be liable for severe fines and penalties.

Initial: _____

Section VI: Standards of Behavior

I, the undersigned individual, understand that I am participating in this observational experience as a volunteer to gain a deeper understanding about careers in the healthcare field and this experience is a privilege for me. I expect no compensation for this observational experience.
I will conduct my observational activities at Mitchell County Hospital Health Systems (MCHHS) only under the supervision of the designated MCHHS employee. I will support the mission, vision and values of MCHHS and the department(s) in which the experience is being obtained.
I agree to support MCHHS's Standards of Behavior. 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. Makeup and nail polish can be used in neutral or moderate shades. Visible tattoos and any other piercings other than ears are to be covered. Cell phone usage is prohibited during your observational period. Please leave in your vehicle or purse/bag.
I agree to conduct my observational activities in a professional manner. I agree to not smoking and not using illegal drugs or alcohol or foul language anywhere on the MCHHS premises.

Per state requirements, we require two forms of identification, one of which must be your driver's license. Please attach a copy of these to this application.

Signature: _____ Date: _____

Printed name of observer: _____

Signature of parent/guardian: _____ Date: _____
(For observers under age 18)

Printed name of parent/guardian: _____