

Nursing Summer Shadowing Experience Details

Program Information

Explore areas including critical care, oncology, obstetrics, leadership, and more during six different shadowing rotations. By the end of the program, you will have experienced more than 15 hours of nursing job shadowing where insights into daily routines and deeper understandings of health care can be gained. At the conclusion of day three, you will have the opportunity to meet with local nursing programs, discover CoxHealth opportunities, and meet with other organizations to learn how you can prepare for a career in nursing.

Dates

Session 1: June 15th – June 17th 2017

or

Session 2: July 13th – July 15th 2017

Times

Day 1: 8:00 am – 5:00 pm

Day 2: 6:30 am – 5:00 pm

Day 3: 6:30 am – 1:00 pm

Please plan to stay for the entirety of the program!

Location

Cox Medical Center South

3801 S. National Ave.

Springfield, MO 65807

Cost: Free!

CoxHealth Nursing Summer Shadowing Experience Application Checklist

This page is for your planning purposes only and does not need to be returned to the CoxHealth Education Center.

- Completed Application Packet
 - Personal Information Page
 - Immunization Record – Be sure to include official documentation for ALL records!
 - Varicella 1
 - Varicella 2
 - Tdap
 - Negative TB test (within the last 12 months)
 - MMR 1
 - MMR 2
- Program Participant Waiver Warning
- Confidentiality and Security Agreement
- Acknowledgement Checklist
- Nursing Interest Ranking Form

The above documents can be sent to the CoxHealth Education Center by:

- Fax: 417-269-4787
- Email: Alexandra.Beydler@CoxHealth.com
- In person/Mail: Education Center

Cox North, K-402
1423 N. Jefferson
Springfield, MO 65802

- Job Shadowing Program Guide Video + Quiz - Completed quiz results will be automatically sent to us!



CoxHealth Nursing Summer Shadowing Experience

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

School (high school or college attending in the fall): _____

Which date are you interested in attending?

June 15th – June 17th 2017

July 13th – July 15th 2017

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 and CoxHealth is not liable if I should experience any unanticipated injury or disease exposure. ***I understand that signing on the line below constitutes a legal signature confirming that I acknowledge and agree that the above information is accurate and correct.***

Job shadower's signature _____

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)



IMMUNIZATION RECORD

Shadower Name _____ Today's date _____

Home Address _____

Contact Phone: _____ Birthday _____ Age _____

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	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)		
Negative TB skin test, or treatment within the last <u>12 months</u>		

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



**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 you acknowledge and agree that you have read and understand the above information.***

DATED this _____ day of _____, 20_____

Parent/legal guardian Printed name (only for minors)

Job shadowing participant name

Parent/legal guardian Signature (only for minors)

Job shadowing participant Signature

Job shadowing participant address

Job shadowing participant phone number and emergency phone number



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: _____



CoxHealth Summer Shadowing Experience
Acknowledgement Checklist
(Initial each item to indicate understanding.)

_____ 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 an approved individual may sign it

_____ I will arrive on time to the Summer Shadowing Experience and stay for the entirety of the program

_____ I will abide by the dress code as outlined in the job shadowing video guide and maintain a neat and clean appearance

Name (printed): _____

Date: _____

Signature: _____



Nursing Interest Ranking Form

In each category below, indicate your interest in the areas by ranking each item starting with 1 being your highest preference. Please assign **each** area a ranking.

Category 1

_____ Cardiology

_____ Orthopedics

_____ Neurology

_____ Pulmonology

_____ Oncology

Category 2

_____ Labor and Delivery

_____ Pediatric Intensive Care

_____ OB/GYN and Nursery

_____ Neonatal Intensive Care

_____ Pediatric Urgent Care

Category 3

_____ Cardiac Critical Care / Medical
Intensive Care

_____ Neuro-trauma Intensive
Care

_____ Cardiopulmonary Rehabilitation

_____ Emergency Medicine

Category 4

_____ Adult Urgent Care

_____ Radiology

_____ Nursing Education

_____ Respiratory Therapy

_____ Nursing Leadership/Management

_____ Transitional/Long Term
Care

_____ Post-Anesthesia Care