
Jan Shipley, Executive Director

Dear Job Shadowing Student,

Enclosed are the forms and instructions you need to participate in the Mid-MO Area Health Education Center Job Shadowing Program. Please read carefully, fill out all the required information, sign and/or fax (573-364-8972) or email **along with a current TB test** to Mid-Mo AHEC at midmojobshadowing@gmail.com

In order to ensure proper processing for your job shadowing request, it is important that ALL pages are COMPLETED and SIGNED as designated. Any incomplete forms will NOT be processed for Job Shadowing requests. All forms, including the TB results page, must be submitted together. Do not send a partial packet, it will not be processed.

Please include an email address that is how you will be contacted regarding your Job Shadowing date and time.

Forms for YOU to keep:

Participant Etiquette

*Shadowing Site Coordinator Evaluation (The Preceptor MUST return your evaluation)

When shadowing at Phelps County Regional Medical Center, about 10 minutes before your shift begins, go to the Registration desk at the Main Entrance and pick up a nametag to wear while you're in the hospital. Return the nametag to the registration desk after your shift is finished. If you fail to return the nametag, you will be billed \$5.00. If you have a student ID, keep it with you at all times regardless of your job-shadowing site.

We hope you enjoy your job shadowing experience and find it helpful in making a career choice. If I can help you in any way, please call or email me at (573) 364-4797, midmojobshadowing@gmail.com. Email is the best way to reach me.

Sincerely,

Mid-Mo AHEC Staff

Mid-Missouri Area Health Education Center

P. (573) 364-4797

F. (573) 364-8972

midmojobshadowing@gmail.com



Mid-Missouri Area Health Education Center

PARTICIPATION AGREEMENT

1.0 Parties to the Agreement

This agreement is made and entered into by and between the Mid-Missouri AHEC, _____ and _____ (hereafter "healthcare facility") (hereafter "participant")

2.0 Purpose

The purpose of this agreement is to establish a temporary work/shadowing/volunteer site for the participant to provide a learning opportunity that will enhance health professions preparation.

3.0 Goals and Objectives

Program goals are to provide meaningful learning experiences for participants interested in healthcare careers and to nurture career interests through educational experiences. Healthcare facility and Mid-Missouri AHEC acknowledge that the experience may include shadowing, patient ambassador activities, or an internship of a clerical nature. This agreement is not intended for clinical training of health professions students.

4.0 Participant Responsibilities

As a participant of the experience at the healthcare facility, the student agrees to:

- 4.1 complete the scheduled experience as required;
4.2 maintain conduct which is professional with regard to spoken and written communication, behavior, punctuality, dependability, physical appearance and program etiquette;
4.3 submit a signed participation agreement, emergency contact information, signed medical and liability releases, a signed confidentiality statement, and a TB skin test or chest x-ray.
4.4 meet and comply with any and all policies and procedures of the healthcare facility, Centers for Disease Control and Occupational Safety & Health Administration (OSHA);
4.4.1 Experiences extending beyond three days (or 24 hours) requires additional documentation of immunizations and employee orientation.
4.5 submit MAHEC data form(s) and experience evaluation to Mid-Missouri AHEC; and
4.6 notify the healthcare provider and regional AHEC immediately, if sick or unable to shadow on a scheduled day.

5.0 Healthcare Facility Responsibilities

The healthcare facility shall:

- 5.1 provide required healthcare facility orientation and instruction regarding OSHA blood borne pathogens and tuberculosis regulations, Corporate Compliance, and HIPPA regulations before the experience begins, as required by the healthcare facility;
5.2 provide on-site supervision of the participant;
5.3 as needed, coordinate with Mid-Missouri AHEC and the student to ensure that student is meeting his/her responsibilities; and
5.4 complete and submit any required evaluations at the end of the experience.

6.0 Mid-Missouri AHEC Responsibilities

The Mid-Missouri AHEC shall:

- 6.1 coordinate/schedule the experience between the participant and the healthcare facility;
6.2 monitor participant's performance through phone calls, e-mail messages, and/or evaluation review;
6.3 maintain periodic contact with the healthcare facility and/or identified health care professional;
6.4 serve as the contact point for questions, comments, or concerns from either the shadowing site representative or the student; and
6.5 collect and maintain documentation concerning the participant in the program, the healthcare facility, and the experience in which the participant was placed.

Signed and agreed to by:

Student Date

Parent/Guardian (if student is under 18) Date

MAHEC Representative

Date



CONFIDENTIALITY AGREEMENT
Visitors to Phelps County Regional Medical Center

Welcome to Phelps County Regional Medical Center. The purpose of this agreement is to help you understand your obligations regarding confidential information that you may have access to. Confidential information includes information about specific patients you may see at the hospital, and/or their medical information.

Confidential information is protected by Federal and State laws, regulations, including HIPAA, and the Joint Commission on Accreditation of Healthcare Organizations standards.

As a visitor, you are required to conduct yourself in strict conformance with applicable laws, standards, and regulations.

In the event that you do have access to confidential information, you hereby agree:

- You will not in any manner discuss, copy, release, sell, loan, review, alter or destroy any confidential information/data.
- You will not misuse confidential information/ data or be careless with it.
- You understand that your obligations under this Agreement will continue after your visit to Phelps County Regional Medical Center ends.
- The release of, or misuse of, patient or hospital information, unless specifically authorized by the patient or covered by hospital policy, shall be cause for legal and/or disciplinary action, up to and including termination.

Printed Name

Signature

Date

Parent Signature required if participant is **under** age 18

Office Use Only:

Purpose for Visit

PCRMC Contact: _____

Department: _____

Extension: _____



Participant Name: _____

Participant Birth Date: _____

Contact Information

In case of medical emergency, Mid-MO AHEC and/or the healthcare facility must be able to contact a parent/guardian or other emergency contact.

Parent/Guardian:

Second Contact:

Name: _____

Name: _____

Address: _____

Relation to student: _____

Home Phone: _____

Home Phone: _____

Work: _____

Work: _____

Other: _____

Other: _____

Release of Liability

I hereby agree that while I am participating in any Mid-MO AHEC educational experience, the Mid-Missouri AHEC, the Missouri AHEC system, and the healthcare facility will not be held responsible for any injury or accident that might occur. Any medical expenses incurred as a result of such injury or accident will be my responsibility.

Student Signature
(Parent/Guardian Signature if participant is under age 18)

Date

Medical Release

(For participants under age 18)

I understand that in case of a medical emergency, every attempt will be made to contact me before medical action is taken. However, this document is my consent as a parent or guardian of the participant for emergency treatment or procedure necessary by the professional staff of the closest hospital available.

Parent/Guardian Signature

Date

Insurance Company

Policy Number

For Office Use Only

Shd Date: _____ Shd Dept: _____
Entered: _____ Initials: _____

Shadowing Availability Form

_____	_____	_____
Last Name	First Name	MI
_____	_____	_____
Home Phone	Cell Phone	XXX-XX _____ last 4 of Social Security
_____	_____	____/____/____
Emergency Contact	Emergency Contact Phone	DOB
_____	_____	_____
Current Address	City	State Zip

Email Address: _____ (This is how you will be contacted)

Program Applying for: _____

Current School: _____

Department wanting to Shadow: _____

We will try to accommodate everyone but because of possible conflicts please list your first, second, and third choice for the next 3 weeks. Also, state what time/day is the best for you if your first 3 options are not available. For example, you are wanting to shadow on Monday the 1st, but you are available any Monday, any-shift, then put *Any Monday, Any Shift*. Also, please be specific with your time.

1st: _____	Time/Day: _____
2nd: _____	Time/Day: _____
3rd: _____	Time/Day: _____

For your reference, the following is a list of the departments with the days and shifts that Shadow shifts can be scheduled. Other departments can be scheduled but please allow 3-5 business days to confirmation.

Resp Therapy: Sun-Sat; Any Shift
ER: Sun-Sat; Any Shift
OB: Sun-Sat; Any Shift

Surg Tech: Mon-Fri; 7:00am-3:30pm only
Radiology: Mon-Fri; 7:00am-3:30pm
Peds: Sun-Sat; Any Shift

PPD Tuberculosis Skin Results Form

*Note: Missouri S&T Students—You can also get this at Student Health on campus.

Consent for PPD Tuberculosis Skin Test

Student Name: _____

I UNDERSTAND job-shadowers must receive a PPD skin test for Tuberculosis as part of pre-job shadowing requirements. I can get a TB test at the **Phelps/Maries County Health Department for \$8.00**. I also UNDERSTAND IT IS MY RESPONSIBILITY to have the test read 48-72 hours after the test is given, by a validated TB test reader. This form **MUST** be returned to the AHEC office with a **Completed** Job Shadowing packet.

My signature indicates my agreement to have the PPD test, and follow up, and further indicates that I HAVE NEVER HAD A POSITIVE PPD TEST IN THE PAST.

Signature

To Be Completed by Health Care Provider

Date of Test

_____ 5 TU/0.1 ml
Pharmaceutical Company

Lot #

Exp. Date

Injection Site

Given by _____

Test results _____ Read by _____ Date _____
Neg Pos

This information may be shared with another Facility or Healthcare provider upon request.
Please initial one: Yes _____ No _____

Keep These Forms

MID-MO AHEC Participant Etiquette

Note: If you agree to Job Shadow, you **MUST** follow through! You **MUST** be on Time and dressed Professionally. Job Shadowing is a Privilege, NOT a right; so please respect it so that we may continue to allow future students to shadow!

- Clean, Professional clothing; collared shirts, dress slacks (khakis is fine), wear comfortable shoes, no heels
- NO hats, spaghetti straps, tank-tops, blue jeans, shorts, opened toed shoes, short skirts
- Hair pulled back and NO visible body piercings, tattoos, or jewelry
- Arrive 10 minutes early to assigned site, introduce yourself, and inform why you are there
- Use polite language, use eye contact; say Thank-You.
- Be respectful and mindful; this is an opportunity and privilege, not an obligation
- No smoking, tobacco chewing, or gum chewing
- Turn your cell-phone **OFF**; NO iPods or other electronic devices
- Everything you hear and see is confidential. You must maintain patient confidentiality
- DO NOT cancel your job shadowing; rescheduling is not guaranteed
- Be mindful of your surroundings; if permissible, ask questions and engage your Preceptors

NOTE: For Rolla Technical Center Students ONLY

Preceptor: Please return the completed evaluation to **RTC,
FAX 573-458-0164:
Your evaluation is a critical part of the application process for RTC!**

Shadowing Site Coordinator Evaluation

Thank you for providing the applicants with a career shadowing opportunity. Your cooperation is very much valued and appreciated. The applicant has signed a waiver of confidentiality. All information you supply will be confidential. The following is a list of characteristics, which we feel are required for a student to successfully complete training in the allied health programs. Please complete the following evaluation by giving us your honest opinion of this experience and return to PCRMC Mid-Mo AHEC. Please **return this evaluation as soon as possible** to allow the applicant to complete the enrollment requirements.

Applicant Name: _____ Date of Shadowing Experience: _____

Program: _____ Preceptor's Name: _____

Site: _____ Phone: _____

5 - Outstanding

2 - Needs Improvement

4 - More than satisfactory

1 - Unsatisfactory

3 - Satisfactory

N/A - Not observed

Description	5	4	3	2	1	N/A
Interest – motivated and eager to learn						
Participation – participated in activities						
Punctuality – arrived on time and prepared						
Attitude – positive approach to staff and others						
Appearance – clean, neat and professional attire						
Professional behavior – positive toward others						
Stress Response – maintains composure and able to function						
Maturity – demonstrates common sense, tact and empathy appropriate for patient care						

Would you like to see this applicant in your facility as a student for clinical rotation? Yes No

ADDITIONAL COMMENTS:

Signature of Preceptor: _____ Date: _____

***Please FAX this to RTC at 573-458-016**

NOTE: For Rolla Technical Center Students ONLY

******: Please mail this shadowing report to: RTC, Office of Student Services, 500 Forum Drive, Rolla, MO 65401. This is a VERY important part**

**RTC/Mid-Missouri AHEC
Shadowing Report (Applicant)**

Applicant Name: _____

Health Care Provider's Name: _____

Hospital/Clinic/Health Department (name and location):

Date(s) and Time(s) of Shadowing Experience(s):

1. What did you do?

2. What did you learn?

3. What did you like or dislike about the experience?

4. Before others participate in shadowing, they should know:

5. My preceptor gave me valuable insight into his/her profession (circle one):

POOR 1 2 3 4 5 GREAT

6. Overall, I would rate my experience (circle one):

POOR 1 2 3 4 5 GREAT

7. I would recommend this shadowing program to others (circle one):

YES NO MAYBE

Additional comments: