

# *Shadow a Health Care Professional Program*



## *Job Shadowing Guidelines*

*~Exploring Health Care Professions in the Tristate~*

*A collaborative program of the Greater Cincinnati Health Council  
and its health care partners.*

**Greater Cincinnati Health Council**

If it involves health,  
we're involved.

[www.gchc.org](http://www.gchc.org)

## **Welcome to the Job Shadowing Experience**

Job Shadowing is an experience offered to students who have a definite interest in a career in the Health Care industry. It allows the student to explore the many opportunities offered by their career interest in a working environment.

During the job shadowing experience, students are paired with a Health Care Professional (Nurse, Radiology Tech, Pharmacist, Respiratory Therapist, Laboratory Technician, etc.). The student is assigned to observe the professional as they continue to do their job.

Job Shadowing will provide the students with:

- a realistic experience in the work day of their career choice
- an opportunity to expand their knowledge about their career interest
- more information about their career choice
- possible financial aid information, including scholarships, to help them obtain their goal.

### **Student Orientation**

Orientations are scheduled after all your completed forms are faxed or mailed to the Health Council. The Council will call you after they receive your paperwork.

Orientation usually can be completed in 60 minutes.

At your orientation meeting you will be given:

- general health care career information and resources
- a general orientation to acquaint you with emergency procedures, safety procedures, infection control practices for an observation role only, as well as HIPAA and confidentiality guidelines
- a hospital-specific confidentiality agreement to sign
- the name and contact number of the facility coordinator so you can set up your shadowing experience

### **Day of Shadowing Experience--What to Expect**

#### **ABSENT**

If you are sick and have a fever, cough, cold, virus or known infection of any kind, please cancel your job shadowing experience and reschedule with your coordinator.

If you are going to be absent:

- call the school counselor/attendance
- call your program coordinator on the packet of information you were given.
- if for some reason YOUR school is closed for the day (snow day, etc...) or you do not feel that you can make it to the shadowing hospital/LTC facility, please follow the guidelines for being absent.

## **TARDY**

If you are going to be 5 to 30 minutes late, notify the hospital and/or the preceptor at the unit number given to you by your coordinator. Leave your full name and the time you were expected to arrive at the hospital/LTC facility.

If you are going to be over 30 minutes late, do not attempt to make it to the shadowing hospital-LTC facility. Follow the guidelines for being absent above.

You are expected to be on time. Please allow yourself adequate time for traveling. Also, familiarize yourself with the location of the facility and the best route to the hospital/LTC facility.

If you do not attend the experience and do not notify the preceptor and/or your school, you will be unable to participate in another “Job Shadow” experience.

## **DRESS CODE**

Proper attire for your shadowing experience is extremely important. For those students who do not adhere to this policy, parents will be notified and they will be dismissed from the shadowing facility.

A few basic rules are:

- Don't dress to extremes (too dressy or too trendy). Use common sense.
- Don't groom to excess (hair, make-up, etc.).
- No cologne, perfume or scented lotions.
- No dangling jewelry, body piercing or visible tattoos (must be covered).
- No jeans or sweatpants.
- No bare midriffs (short or cropped shirts).
- Shoulder length or longer hair must be out of face.
- Wear clean tennis shoes or other comfortable shoes (closed-toed). No sandals or open-toed shoes.
- Wear socks or stockings.
- Be neat, clean and tidy-looking. Do not wear clothes that reveal bare skin, that are baggy, or that drag the floor.

## **CONDUCT**

It is important to realize that:

- you are a guest at the hospital/LTC facility
- you are expected to be courteous and respectful at all times
- you should display active listening skills and a positive attitude.

If at any time the health care professional you are paired with feels your conduct is inappropriate or disrespectful, you will be asked to leave the hospital/LTC Facility and your school will be notified.

## **MISCELLANEOUS**

Please do not take to the hospital anything that you don't really need.

Examples:

- Purses or backpacks (lock in the trunk of your vehicle if you are driving)
- Money (large amounts)
- Miscellaneous items (books, magazines, journals, etc)
- Cell phones (not allowed to use in hospital) and/or pagers.

## **SMOKING**

Hospitals are nonsmoking facilities, please be aware that you will not be allowed to smoke on site.

## **PHYSICAL ABILITY**

It is essential that you are physically able to follow the health care professional while in the shadowing experience (i.e., any physical ailment that would require crutches/braces, etc. might hamper the ambulation of a student and become a safety hazard). For example: if you were on crutches or in a leg brace, you would not be able to follow a nurse. On the other hand, a student in a wheelchair might be able to observe someone in the lab or someone in a health care position that would not require ambulation.

## **IMPORTANT CONTACT INFORMATION**

Shadowing Program Staff

**Mary Duffey, BSN RN PHR, Director, Health Care Workforce Center 513-878-2862**

**Sharon Trainer, Project Assistant 513-878-2856**

**GREATER CINCINNATI HEALTH COUNCIL (513)531-0200 Fax 513.531.0278**  
**2100 Sherman Avenue, #100**  
**Cincinnati, OH 45212-2775**

## FREQUENTLY ASKED QUESTIONS:

What do I do when I have completed all application forms and collected my immunization records?

**Fax or mail all forms to the Greater Cincinnati Health Council. You will then be called to schedule an orientation appointment.**

If I get sick the night before the shadowing day, what do I need to do?

**Call the school and the Hospital Preceptor/LTC Facility Coordinator to let them know you will not be coming.**

If I find out that I can't make it to the shadowing day, what do I need to do?

**Call the school and the Hospital Preceptor/LTC Facility as soon as possible and reschedule for a later date.**

What if the weather is really bad (snow, ice, etc...) and I don't feel comfortable driving or can't drive?

**Call the school and the hospital/LTC Coordinator.**

What if I get lost on my way to the hospital?

**As soon as you realize you are lost and are going to be late, call the preceptor for directions. If they are not available, try the main number of the hospital/LTC facility. You should have the numbers with your paperwork.**

What do I need to take with me on the day of shadowing?

**You need only take the directions, your completed forms/paperwork, and your name badge. DO NOT take any unnecessary items into the facility.**

**Participant Form**

Name \_\_\_\_\_ Phone# \_\_\_\_\_

Address \_\_\_\_\_ School \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ E-mail \_\_\_\_\_

Personal Physician's Name \_\_\_\_\_ Phone# \_\_\_\_\_

To shadow, the following steps must be taken:

\_\_\_\_\_ Complete & sign this participant/permission form – obtain parent/guardian signature if under 18 years of age (must be at least 16 years of age to shadow)

\_\_\_\_\_ Complete an emergency medical authorization form

\_\_\_\_\_ Send a copy of an up-to-date immunization record

\*the MMR (measles-mumps-rubella) vaccine must have been given within the 1980's or 1990's

\_\_\_\_\_ Provide proof of a two-step TB skin test (actually two tests & results) within the past year --please refer questions to your private physician NOTE: St Elizabeth in KY requires only one TB test

\_\_\_\_\_ FAX or MAIL all forms to the Greater Cincinnati Health Council (GCHC)

\_\_\_\_\_ Attend an orientation program at GCHC---scheduled after all forms are received by the Council

\_\_\_\_\_ Sign a confidentiality agreement (you will be given this during your orientation)

If under 18 years of age:

I, the undersigned, herewith consent that my daughter/son \_\_\_\_\_ may observe at the health care facility assigned for a job shadowing experience, and I expressly release that institution and the Greater Cincinnati Health Council from any and all claims which arise out of the observation experience.

Signature \_\_\_\_\_

Parent or Guardian

I, the observer, hereby consent to follow all of the rules set forth in this job shadowing experience. I realize I must act responsibly and professionally in this role, and I also understand that I am to act as an observer only and am not permitted to act in any role other than that of an observer.

Signature \_\_\_\_\_

Shadowing Participant

**Please check which organization you are interested in shadowing with and circle the site you prefer:**

\_\_\_\_\_ TriHealth (Bethesda Arrow Springs, Bethesda North, Good Samaritan)

\_\_\_\_\_ Mercy Health Partners (Western Hills, Mt. Airy, Anderson, Clermont, Fairfield)

\_\_\_\_\_ Health Alliance (Jewish Kenwood, The University Hospital, Drake Center, Fort Hamilton)

\_\_\_\_\_ The Christ Hospital

\_\_\_\_\_ St. Elizabeth Medical Center (North, South, Grant County, Family Practice Center)

\_\_\_\_\_ Dearborn County Hospital

Area of interest or occupation you would like to observe: \_\_\_\_\_

*The following is optional, but is used for grant purposes to report the diversity of participants.*

*Please check sex:* \_\_\_\_\_ *Male* \_\_\_\_\_ *Female*

*Please check race:* \_\_\_\_\_ *African American* \_\_\_\_\_ *Alaska Native* \_\_\_\_\_ *Asian* \_\_\_\_\_ *Hispanic*

\_\_\_\_\_ *Native American* \_\_\_\_\_ *Pacific Islander* \_\_\_\_\_ *Caucasian* \_\_\_\_\_ *Other*

*No person shall, on a basis of race, color, national origin, sex, age, weight, height, marital status, or disability be excluded from participation in job shadowing.*

**\*\*A copy of this form, your immunization records, and an emergency medical authorization form (if applicable), must be sent (mail or fax) to the Health Council prior to your orientation.**

**The orientation date will be scheduled after paperwork is received by the Health Council. It is recommended that only copies (not originals) of immunizations are sent to the Health Council.**

**Greater Cincinnati Health Council  
2100 Sherman Ave. Suite 100  
Cincinnati, OH 45212-2775**

**Fax 513-531-0278**

**EMERGENCY MEDICAL AUTHORIZATION**

Observer/Student Name \_\_\_\_\_

Observer/Student Home Address \_\_\_\_\_

Observer/Student Home Phone No. \_\_\_\_\_

Parent or Guardian's Name \_\_\_\_\_

Parent or Guardian's Home Address \_\_\_\_\_

Parent or Guardian's Phone No. \_\_\_\_\_ Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

The purpose of this document is to enable parents and guardians to authorize the provision of emergency medical treatment for minor observers who become ill or injured while at the facility when the parents or guardians of such observers cannot be reached.

In the event reasonable attempts to contact one of the above persons, at the telephone numbers listed, have been unsuccessful, I WILL HEREBY GIVE MY CONSENT FOR:

- 1) the administration of any treatment deemed necessary by the following preferred physician, Dr. \_\_\_\_\_, phone number \_\_\_\_\_; or the following preferred dentist, Dr. \_\_\_\_\_, phone number \_\_\_\_\_, or, in the event the designated preferred practitioner is not available by another licensed physician or dentist; and
- 2) the treatment of the minor observer at \_\_\_\_\_ or any other hospital to which the minor may be transferred.

This authorization does not cover major surgery unless the medical opinion of two other licensed physicians or dentists, concurring in the necessity of such surgery are obtained prior to the performance of such surgery.

Facts concerning the minor observer's medical history including allergies, medications being taken, any physical impairment to which the physician should be alerted is the following:

\_\_\_\_\_

Medicines: \_\_\_\_\_ Allergies: \_\_\_\_\_

Please circle one:

Yes NO Have you had the chicken pox?

Yes NO If NO above, have you had a recent exposure to chicken pox (within the last 2 weeks)?

\_\_\_\_\_  
Parent or Guardian

\_\_\_\_\_  
Date

I DO NOT GIVE MY CONSENT for emergency medical treatment to my child. In the event of illness or injury requiring emergency medical or dental treatment, I wish \_\_\_\_\_ to take no action or to do the following:

\_\_\_\_\_

\_\_\_\_\_  
Parent or Guardian

\_\_\_\_\_  
Date

**\*\*A copy of this form must be mailed or faxed (bring originals to orientation) to the Health Council to receive an orientation date.**