

Shadow a Health Care Professional Program



Job Shadowing Guidelines

~Exploring Health Care Professions in the Tri State~

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



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Welcome to the Job Shadowing Experience

Job Shadowing is an experience offered to individuals who have a definite interest in a career in the health care industry. It allows the individual to explore the many opportunities offered by their career interest in a working environment.

During the job shadowing experience, individuals are paired with a health care professional (Nurse, Radiology Tech, Pharmacist, Respiratory Therapist, Laboratory Technician, etc.). They are assigned to observe the professional as they continue to do their job.

Job Shadowing provides:

- 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.

Participant Orientation

An orientation is required for shadowing in any participating hospital. Orientations are scheduled after completed forms are submitted (fax, email or mail) to the Health Council. The Council will contact you after your paperwork is received and reviewed. Orientations last approximately 1 to 1 ½ hours.

At your orientation you will be given:

- general health care career information and resources
- HIPAA training & quiz and confidentiality guidelines
- a hospital-specific confidentiality agreement to sign
- a general orientation to acquaint you with emergency procedures, safety procedures, infection control practices, program expectations and parameters
- job shadowing name badge
- the name and contact number of the respective hospital coordinator(s) for scheduling the 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 hospital program coordinator or department manager
- 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

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 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.

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

DRESS CODE

Proper attire for your shadowing experience is extremely important. For those individuals who do not adhere to this policy, notification will be made and they will be dismissed from the shadowing facility and/or the shadowing program.

A few basic rules are:

- Don't dress to extremes (too dressy or too trendy). Use common sense.
- No cologne, perfume or scented lotions.
- No dangling jewelry, body piercing or visible tattoos (must be covered).
- No jeans or sweatpants or shorts.
- 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. No high heels. 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.

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 (no large amounts)
- Miscellaneous items (books, magazines, journals, etc)
- Cell phones (not allowed to use in hospital) and/or pagers.

SMOKING

Hospitals are non-smoking 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

Sharon Trainer, Health Care Workforce Center Project Coordinator
513-878-2856, strainer@gchc.org Fax 513.531.0278

GREATER CINCINNATI HEALTH COUNCIL (513)531-0200
2100 Sherman Avenue, Suite 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, email or mail all forms to the Greater Cincinnati Health Council (FAX 513.531.0278, EMAIL strainer@gchc.org or MAIL to 2100 Sherman Avenue Suite 100 Cincinnati, OH 45212. You will then be contacted to schedule an orientation class.

If I get sick the night before the shadowing day or if I find out I can't make it to the appointment, what do I need to do?

As soon as possible, call the hospital coordinator or preceptor to let them know you will not be coming 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 hospital to let them know you will not be able to attend.

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 contact 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 (NOTE: must be at least 16 years of age to shadow)

_____ Complete an emergency medical authorization form (if under 18, parent/guardian must sign)

_____ 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, EMAIL or MAIL all forms to the Greater Cincinnati Health Council

_____ Attend an orientation class at the Health Council---scheduled after all forms are submitted

_____ 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(s) you are interested in shadowing with and circle the site(s) you prefer:

_____ The Christ Hospital

_____ Dearborn County Hospital

_____ Fort Hamilton Hospital

_____ Mercy Health (Anderson, Clermont, Fairfield, Mt. Airy, Western Hills, The Jewish Hospital)

_____ St. Elizabeth Healthcare (Covington, Edgewood, Falmouth, Florence, Ft. Thomas, Grant)

_____ TriHealth (Bethesda Arrow Springs, Bethesda North Hospital, Good Samaritan Hospital)

_____ UC Health (Drake Center, University Hospital, West Chester 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 (fax, email or mail) 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 EMAIL strainer@gchc.org

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