

## **Instructions for Completing Student Observation (Job Shadowing) Agreement**

Step by step instructions for filling out the Student Observation (Job Shadowing) Agreement Form are listed below for your convenience. If you have additional questions or need assistance, please do not hesitate to contact Nancy Weikel, Instructor, Student Services, at (260) 373-7222, or email her at [Nancy.Weikel@parkview.com](mailto:Nancy.Weikel@parkview.com). You may also contact Johnathan Liechty, Manager of Student Services, at (260) 373-7250, or email him at [Johnathan.Liechty@parkview.com](mailto:Johnathan.Liechty@parkview.com).

First Blank Line: Student/Individual's name

Second Blank Line: Student/Individual's address (Street, City, State, Zip)

Third Blank Line: Please include ALL of the following details:  
Location desired (i.e. Parkview Hospital, Parkview Whitley, etc)  
Unit/Department desired: (i.e. Pediatrics, Radiology, ER, etc.)  
Date/Time desired (i.e. 05/25/09 from 8am to 2pm)

Fourth Blank Line: Date Requested

Fifth Blank Line: (Bottom of page, right side)  
Signature of Student/Individual  
Birth date of Student/Individual  
Parent/Guardian signature (if applicable)

### **Completed forms should be mailed to:**

**Parkview Student Services  
Parkview Health  
2200 Randallia Drive  
Fort Wayne, IN 46805**

### **Completed forms may also be faxed to:**

**(260) 373-3168  
Attn: Student Services**

# STUDENT OBSERVATION AGREEMENT

## BY AND BETWEEN

Parkview Hospital, Inc., Huntington Memorial Hospital, Inc. d/b/a Parkview Huntington Hospital, Whitley Memorial Hospital, Inc. d/b/a Parkview Whitley Hospital, Community Hospital of Noble County, Inc. d/b/a Parkview Noble Hospital, Community Hospital of LaGrange County, Inc. d/b/a Parkview LaGrange Hospital and The Orthopaedic Hospital at Parkview North LLC (Facility)

## AND

\_\_\_\_\_, whose address is \_\_\_\_\_  
(Student/Individual),

WHEREAS, the Facility is organized for the purpose of operating a health care facility, including the operation of a \_\_\_\_\_ department; and,

In consideration of the mutual understanding that the student observation experience will be offered to allow the Student/Individual to gain in-depth knowledge about a specific health career and that the experience will consist of observational experiences only:

### Section 1. Relationship of Parties

Observation Student/Individual shall not be deemed to be an employee or agent of Facility or of Parkview Health, Inc. ("PH").

### Section 2. Responsibilities of the Student/Individual

With respect to the Program identified in this Agreement, the Student/Individual agrees that he/she:

- (a) Has read and understands the accompanying Guide for Shadowing Experience including information on Occupational Health and Safety Administration ("OSHA") Blood-Borne Pathogen Regulations, Hazardous Materials, Fire Safety/Codes, Infection Control and Infectious Waste;
- (b) May be required to wear gloves, masks/face shields or other protective clothing;
- (c) Submits a signed "Confidentiality Agreement" to the Facility representative; agrees to dress in the appropriate manner for the professional environment (no jeans, shorts or sandals);
- (d) Will act in a professional manner in their observational role while at the Facility.

The student will be solely responsible for expenses incurred during the observation educational experience regardless of whether such expenses are:

- (a) For health care services provided by Facility, or
- (b) Otherwise incurred in connection with the observation educational experience.

Section 3. Responsibilities of the Facility Representative

With respect to the Program identified in this Agreement, the Facility representative shall:

- (a) Serve as a health care representative which Observation Student(s)/Individual(s) may be allowed to watch in selected roles, and assure that the experience is limited to only observation activities;
- (b) Retain ultimate responsibility for patient care, ensuring that Facility staff direct or supervise all aspects of patient care.

Section 4. Term

It is understood and agreed that the term of this Agreement shall be from \_\_\_\_\_ to \_\_\_\_\_.

The parties have caused this Agreement to be executed and limited to the later day and year written below.

"FACILITY"

"STUDENT/INDIVIDUAL"

Parkview Hospital, Inc., Huntington  
Memorial Hospital, Inc. d/b/a Parkview  
Huntington Hospital, Whitley Memorial  
Hospital, Inc. d/b/a Parkview Whitley  
Hospital, Community Hospital of Noble  
County, Inc. d/b/a Parkview Noble Hospital,  
Community Hospital of LaGrange County,  
Inc. d/b/a Parkview LaGrange Hospital and  
The Orthopaedic Hospital at Parkview North LLC

BY: \_\_\_\_\_

BY: \_\_\_\_\_

Its: \_\_\_\_\_

Its: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

Birthdate: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

BY: \_\_\_\_\_

Parent's signature if student/individual is under age of 18.



# CONFIDENTIALITY

## What does it mean?

**Confidentiality** means “keeping information private.” In a hospital or healthcare setting, all patient information is considered confidential. Any information about patients that is spoken, on paper, or on computer is to be kept private. You cannot tell your family, friends, or anyone else (who is not taking care of the patient) about this information.

Examples of confidential information include:

- **Name**
- **Address**
- **Age**
- **Social Security Number**
- **Whether someone is in the hospital**
- **Diagnosis or reason why a person is in the hospital**
- **Treatments and medications**
- **Test results**
- **Past health conditions**

*If you share any of these types of information with people who do not need to know, you have broken confidentiality—and **you have broken the law!***

In addition to patient information, confidentiality must also include privacy of:

- **business-related information**
- **fellow employee personal and employment information**

PARKVIEW HEALTH  
CONFIDENTIALITY AGREEMENT

I understand that in the performance of my duties as an employee, or Board member, a member of the Medical Staff or as an agent of Parkview Health (“PH”) or a PH affiliated entity (collectively “Parkview”), I am required and privileged to have access to and am involved in the processing of verbal, written, computer generated, computer accessed, filmed, and/or recorded information related to patients, physicians, employees and business information, all identified as “Confidential Information”, as defined by the Parkview Health Confidentiality Policy. I understand that I am obliged to protect and maintain the confidentiality of this Confidential Information at all times.

I acknowledge that if my position requires application of an electronic signature code, it is the equivalent of my legal handwritten signature. I understand that if I disregard the confidentiality of my electronic signature code, use the code of another person, or fail to comply with these confidentiality requirements, I will be committing an illegal and/or unprofessional act.

I understand that a violation of these confidentiality considerations may result in disciplinary action, up to and including termination from my position or legal action.

I certify by my signature that I have knowledge of the provisions of the Confidentiality Policy. I agree to adhere to and uphold Parkview Confidential Information.

Name: \_\_\_\_\_  
(please print)

Signature: \_\_\_\_\_

Employee Number (if applicable): \_\_\_\_\_ Date: \_\_\_\_\_