Virginia Mason Franciscan Health

OBSERVATION APPLICATION

Where would you like to complete your observation? *Please choose one.*

□ **St. Anne Hospital** (Burien) □ **St. Anthony Hospital** (Gig Harbor) □ **St. Clare Hospital** (Lakewood)
□ **St. Elizabeth Hospital** (Enumclaw) □ **St. Francis Hospital** (Federal Way) □ **St. Joseph Medical Center** (Tacoma)
☑ **St. Michael Medical Center** (Silverdale)

Why are you interested in completing this shadow? *Please choose one.*

□ Considering Career Change □ Graduation Requirement □ Prerequisite for Schooling

LAST Name: _____ **FIRST Name:** _____ **Nickname:** _____

Email: _____ **Cell Phone:** _____ **Home Phone:**_____
□ *OK to call me here* □ *OK to call me here*

Home Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Are you over the age of 16? ☑ **YES** □ **NO**
You must be at least 16 years of age in order to complete a job shadow. Please note that some departments are closed to persons under the age of 18 including Emergency, Labor & Delivery and Surgery.

Are you a student? ☑ **YES** □ **NO** If yes, where are you attending school? Kitsap County EMS

If this observation is required by your school, complete the following:

Teacher's/Professor's Name:_____ Phone Number: _____

# of hours required: 8 *Observations are limited to a maximum of 8 hours & must be completed in a day.*

What job or department are you interested in shadowing: Emergency Room

If there is a specific employee you are hoping to shadow, please list a name. _____

Please indicate the days you are available to complete a shadow:
□ Mondays □ Tuesdays □ Wednesdays □ Thursdays □ Fridays

Time of day:
□ Morning □ Afternoon

Participants must provide documentation confirming two MMR (Measles/Mumps/Rubella) vaccinations or Titer Test results confirming immunity to MMR. Must provide documentation of one COVID vaccination (J&J) or two COVID vaccinations (Moderna or Pfizer). During flu season (November-April), participants must provide documentation of a current flu vaccination. Virginia Mason Franciscan Health does not provide any health insurance coverage to shadow participants. Please list someone we may contact in case of an emergency (illness, injury or immediate medical attention).

Name:_____ Phone 1: _____ Phone 2: _____

In being granted permission to observe at this Virginia Mason Franciscan Health facility, I agree to:

1. Abide by the Virginia Mason Franciscan Health mission, vision, values and policies.
2. Follow the rules and the directions of the employee that I am assigned to do my observation.
3. Remain in the area where I am assigned.
4. Protect the privacy of every patient and keep confidential all that I view and hear while observing.

_____ _____
Applicant's Signature **Date**

FOR PARTICIPANTS UNDER AGE 18, PARENTAL OR GUARDIAN PERMISSION & SIGNATURE IS REQUIRED BELOW.

I give my permission for my child to participate in observing at this Virginia Mason Franciscan Health (VMFH) facility. I understand that as a participant, my child may be subjected to viewing procedure or patient that may involve visible wounds, bodily fluids and nudity. By allowing my child to participate, I will not hold VMFH responsible or liable. In the event I cannot be reached, I give permission to VMFH to provide any necessary treatment to my child in case of illness or injury.

_____ _____ _____
Parent's Name (please print) **Parent's Signature** **Date**

Virginia Mason Franciscan Health

OBSERVATION CONFIDENTIALITY AGREEMENT

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law imposed on all health care organizations that requires us to take measures to safeguard patient information. Any **P**rotected **H**ealth **I**nformation **(PHI)** about a patient that is written on paper, saved on computer or spoken needs to be safeguarded and is considered confidential.

Protected **H**ealth **I**nformation **(PHI) includes and is not limited to:** name, address, city, precinct, zip code, telephone number, birth date, social security number, medical record number, health plan beneficiary number, account number, certificate, license number, vehicle and serial number, license plate number, biometric identifiers, device identifiers/serial numbers, fax number, email address, internet protocol number, web universal resource locator (URL), admission date, discharge date and date of death.

Authorizations
Organizations must obtain authorization from a patient before using or sharing their PHI. A patient may revoke an authorization at any time by making a written request.

Notice of Privacy Practices
Patients receives a copy of this notice. It informs the patient with all of the ways our organization uses and shares patient information. It also explains the patient's rights to confidentiality and access to his/her information.

Confidentiality

- ✓ Keep information you hear about a patient to yourself.
- ✓ Do not discuss patient information.
- ✓ Do not look at any patient information unless you are asked to.

Penalties for <u>Anyone</u> Violating These Privacy Rules

- ✓ Criminal penalties: a felony with maximum of 10 years in jail and up to $250,000 in fines
- ✓ Civil penalties: maximum fine of $25,000 per violation

I understand and agree that all patient information is strictly confidential and is protected in every form, including written records, reports, correspondence, oral communications computer programs and applications In being given the privilege of observing at this Virginia Mason Franciscan Health facility, I understand and agree to keep all information and confidential and never refer to a patient's identify, diagnosis, condition or treatment.

I understand and agree that staff information is confidential. Staff addresses, phone numbers, work schedules and all other personal information shall not be shared with anyone without the permission of the staff member.

I understand and agree that as an observer at this Virginia Mason Franciscan Health facility, any violation of this confidentiality policy will result in corrective action including termination**.**

I understand and agree that my obligations under this agreement continue after my observation ends.

_____	_____	_____
Printed Name	**Signature**	**Date**

Virginia Mason Franciscan Health

Child and Adult Abuse Information Act
Background Check Authorization

Yes ☐ **No** ☐ **Have you ever been convicted of a crime against persons? A crime against persons includes any of the following offenses:** aggravated murder; first or second degree murder; first or second degree kidnapping; first, second or third degree assault; first, second or third degree rape; first, second or third degree statutory rape; first or second degree robbery; first degree arson; first or second degree manslaughter; first degree burglary; first or second degree extortion; indecent liberties; incest; vehicular homicide; first degree promotion prostitution; communication with a minor; unlawful imprisonment; simple assault; sexual exploitation of minors; first or second degree criminal mistreatment; or any of these crimes as they may be renamed in the future.

Yes ☐ **No** ☐ **Have you ever been found, in a disciplinary action, domestic relations proceeding or disciplinary board final decision, to have sexually assaulted or exploited a minor or to have sexually abused a minor?**

Yes ☐ **No** ☐ **Have you ever been convicted of (a) crime(s) related to drugs? "Related to drugs" means manufacture, delivery or possession with intent to manufacture or deliver a controlled substance.**

Yes ☐ **No** ☐ **Have you ever been found in a dependency action to have sexually assaulted or exploited any minor or been found guilty of child neglect or abuse or to have physically abused any minor.**

Yes ☐ **No** ☐ **Have you been arrested or convicted of any offense in the past seven (7) years?**

Yes ☐ **No** ☐ **Have you been released from prison in the past seven (7) years?**

If your answer is YES to any of the above questions, please describe and provide the date(s) of the findings(s) and the penalty (penalties) imposed on the back of this paper. Attach additional pages as necessary.

We require your legal name and birth date, plus other information, to obtain from the Washington State Patrol criminal identification system, a report of your record and criminal convictions for offenses against persons, civil adjudications of child abuse and disciplinary board final decisions. A thumbprint may be required to later verify information received from the State Patrol. We will make a copy of the report available to you upon your request.

Applicant's Name: Last: _____ First: _____ Middle: _____

Alias or Maiden Name: _____ Date of Birth: _____ Sex: _____

Driver's License #: _____ State: _____ Expiration Date: _____

I understand that my observation status is conditional and requires a satisfactory report from the Washington State Patrol. I understand that I will not be accepted to observe for any misrepresentation or omission to the questions listed above. I confirm that the above information is true, accurate and complete.

Signature:_____**Date:** _____