Job Shadowing Application

Contact Information

Name: _____
First MI Last

Address: _____

City, State, Zip: _____

DOB: _____

Email: _____

Phone: _____

Emergency Contact: _____

Emergency Contact Phone Number: _____

Name of School Currently Attending: _____

Year in School _____

Please provide any special accommodation needs: _____

Do you have any relatives that work at RCH? _____

If yes, please provide their full name _____

Occupations/Career Interest

Identify dates or time frame you would like for you job shadow request:

Required Information

As part of the application process, I agree to provide all required information for approval prior to my visit as a job shadow. Required information includes:

1. Signed Job Shadow Agreement
2. Immunization history
3. TB Assessment

Job Shadowing Agreement

Instructions for Completing the Forms:
Carefully read each section of the form.
Fill out all the required fields.
Sign and date the form in the designated areas.
Submit the completed form to Jessica Bishop, Human Resources Director
Email: hr@rchmtayr.org Phone: 641-464-4548.

Acknowledgment of Risk

I, the undersigned, acknowledge that participation in clinical activities at Ringgold County Hospital involves inherent risks, including but not limited to:

- Exposure to infectious diseases
- Exposure to hazardous materials
- Physical injury from medical procedures or equipment
- Emotional and psychological stress from patient care

I understand that while Ringgold County Hospital and its staff will take all reasonable measures to minimize these risks, they cannot guarantee my safety. I acknowledge that my participation is voluntary, and I assume all associated risks.

Release of Liability

In consideration of being permitted to participate in the clinical activities at Ringgold County Hospital, I, for myself, executors, and administrators, hereby release and discharge Ringgold County Hospital, its trustees, officers, employees, agents, and representatives from any and all claims, demands, actions, and causes of action, arising out of or related to any loss, damage, or injury, that may be sustained by me while participating in these activities.

Confidentiality and HIPAA Agreement

As a participant in clinical activities at Ringgold County Hospital I understand and agree to maintain the strict confidentiality of all patient information and hospital operations to which I may be exposed during my visit. I acknowledge that patient confidentiality is of utmost importance and is protected by federal and state laws, including the Health Insurance Portability and Accountability Act (HIPAA).

I understand that HIPAA regulations govern the use and disclosure of protected health information (PHI) and impose strict requirements on healthcare providers and their affiliates. I agree to comply fully with HIPAA regulations and all hospital policies and procedures related to the safeguarding of PHI.

Compliance with Hospital Policies

I agree to adhere to all policies, procedures, and guidelines of Ringgold County Hospital during my visit, including those related to health and safety, infection control, and professional conduct. I understand that failure to comply with these policies may result in the termination of my visit and potential disciplinary action by my academic institution.

Medical Insurance

I confirm that I have current and adequate health insurance coverage. I understand that Ringgold County Hospital is not responsible for any medical expenses incurred as a result of my participation in the clinical activities.

Insurance Provider: _____

Policy Number: _____

Immunization Information and Release

Immunization and proof of vaccination information must be received before acceptance into an in-person job shadow experience.
Provide *acceptable medical evidence that you have received the below immunizations to participate in any in-person job shadow. RCH will not provide any of these immunizations; they are at the expense of the participant.

1. Submit a copy of your immunizations as part of your application. If this is not received as part of your application, you will not be able to participate, and your application may be closed without notification.
2. Immunization required:
    a. Measles, Mumps, Rubella (MMR): Two valid doses of MMR vaccine or laboratory results indicating evidence of immunity to Measles, Mumps, and Rubella.
    b. Influenza Vaccination
    c. TDAP: Tdap vaccination administered within 10 years.
    d. Tuberculosis Screening/Testing: IGRA (blood test) within 90 days of start or two step TST (skin test) one complete within 90 days, one within 12 months of start.
    e. Chickenpox (Varicella): Two valid doses of Varicella vaccine or laboratory results indicating evidence of immunity to Varicella.

*Acceptable documentation may include physician records, military records, employer records, school records, IRIS immunization record, hospital record, and immigration documentation. Hand-written records need to be on official letterhead with an official signature.

If your records are within the state of Iowa, RCH can pull those records from IRIS with your release.

Please fill out and sign the release.

Authorization for Request of Medical Information

Authorization Details:
I hereby authorize the release of my (or my dependent's) immunization records to Ringgold County Hospital.

Purpose of Request:
☒ Job Shadow
☐ Other (specify): _____

Acknowledgment of Medical Release:
I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to the Director of Health Information at Ringgold County Hospital or Mount Ayr Medical Clinic. I understand that I have the right to inspect the information to be disclosed upon proper notification to and under appropriate conditions established by Ringgold County Hospital or Mount Ayr Medical Clinic. I understand that my healthcare and payment for my healthcare will not be affected if I do not sign this form. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations, I understand this authorization is voluntary.

Consent and Signature

By signing below, I acknowledge that I have read and understand the Job Shadow Application, Agreement Form, and Medical Release forms and that I voluntarily agree to its terms.

Participant Signature: _____ Date: _____

If the participant is under 18 years of age, a legal guardian must also sign.

Guardian Signature: _____ Date:_____

Relationship: _____

Phone: _____

Iowa Department of Public Health

Tuberculosis Control Program

TB Screening Form

Name:_____ DOB:_____

Signs and Symptoms of TB Disease Persons who answer "yes" to any of the following signs and symptoms warrant further investigation to rule out active infectious pulmonary/laryngeal TB.	Yes	No
1. Productive cough of more than three (3) weeks duration	☐	☐
2. Coughing up blood	☐	☐
3. Persistent fevers	☐	☐
4. Drenching night sweats	☐	☐
5. Unplanned weight loss	☐	☐

This assessment was completed by (print name):_____

Signature:_____ Date of assessment:_____

If referral is needed list the name of provider/clinic to which the person was referred:

_____