

*Shadow A Health Care Professional
Program*

Job Shadowing Guidelines

*Exploring the health care profession in the Tri-state Area.
A program of The Greater Cincinnati Health Council*

*Our thanks to the Northeast Ohio Nursing Initiative (NEONI) for
their contribution to the concepts of this program*

Greater Cincinnati **Health Council**

If it involves health,
we're involved.

Participating Health Care Facilities



**Websites can assist you with travel directions.*

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 learning 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:

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

Student Orientation

At your orientation meeting you will be given:

- A General orientation to acquaint you with emergency and safety procedures as well as HIPAA and confidentiality guidelines.
- The name and contact number of the facility coordinator so you can set up your shadowing.
- A badge that must be worn during the shadowing experience
- Confidentiality statement to sign
- Participant form
- Permission signature if under 18 years of age and over 16(required)
- Emergency authorization form

Day of Shadowing Experience...What to Expect

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.

Tardy

If you are going to be **5 to 30 minutes late**

Call 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 below.

If you are going to be absent:

Call:

- the school counselor/attendance (back of handbook)
- Please call your 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.

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

If you **do not** attend the experience and **do not** notify the preceptor and your school, you will be **unable** to have another "Shadow-A Healthcare Professional" 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 form 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.
- Wear socks or stockings
- Be neat, clean and tidy looking. Do not wear clothes that reveal bare skin, are baggy or drag the floor.

Conduct

It is important to realize that:

- You are a **guest** at the hospital/LTC facility.
- You are expected to act courteously and respectfully 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 bring 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)
 - Misc. items (books, magazines, journals, etc)
 - Cell phones (not allowed to use in hospital) and 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 healthcare professional while in the shadowing experience, i.e. any physical ailment that would require crutches/braces etc..that might hamper the ambulation of a student and become a safety hazard. For example: You would not be on crutches or be in a leg brace and 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 healthcare position that would not require ambulation.

Frequently Asked Questions:

- Q. If I get sick the night before the shadowing day what do I need to do?**
- A. Call the school and the hospital preceptor/LTC Facility Coordinator by 7:30am.**
- Q. If I find out that I can't make it to the shadowing day, what do I need to do?**
- A. Call the school and the hospital preceptor/LTC Facility by 7:30am.**
- Q. What if the weather is really bad (snow, ice, etc...) and I don't feel comfortable driving or can't drive?**
- A. Call the school and the hospital/LTC coordinator by 7:30am.**
- Q. What if I get lost on my way to the hospital?**
- A. As soon as you realize you are lost and are going to be late, call the hospital/LTC preceptor for directions. If they are not available, try the main number of the hospital/LTC facility (on may use the sheet that was attached to application).**
- Q. What do I need to bring on the day of shadowing?**
- A. You don't need to bring anything, except for map, directions and this booklet.**

Important Phone & Fax Numbers and Mailing Address to return participant/Emergency Medical Authorization forms:

Shadowing Program Staff

Mary Duffey, BSN RN PHR, Director Health Care Workforce Center
Greater Cincinnati Health Council, 2100 Sherman Avenue, #100,
Cincinnati, OH 45212-2775, P: 513/531-0200 Ext 114, F: 513/531-0278

Lisa Sharpe, Administrative Coordinator
Greater Cincinnati Health Council, 2100 Sherman Avenue, #100,
Cincinnati, OH 45212-2775, P: 513/531-0200 Ext 115, F: 513/531-0278

The Healthcare Professional Job Shadowing Program is sponsored by The Greater Cincinnati Health Council

Participant Form

Name _____ Phone# _____

Address _____ School _____

City _____ State _____ Zip _____

To shadow the following steps must be taken:

_____ Sign appropriate permission if under 18 years of age (must be at least 16 years of age)

_____ Attend an orientation program at the Greater Cincinnati Health Council

_____ Send a copy of an up-to-date immunization record.

The M-M-R (measles-mumps-rubella) vaccine had to have been given within the 1980's or 1990's.

Proof of a two-step TB skin test within the past year. (Please refer questions to your private physician)

_____ Complete an emergency medical form

_____ Sign a confidentiality statement (You will be given this during your orientation)

Personal Physician's Name _____ Phone# _____

If under 18 years of age:

I, the undersigned, herewith consent that my daughter/son _____

May observe at the healthcare 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 professional 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 and circle the site you are interested in job shadowing:

_____ TriHealth (Bethesda North, Good Samaritan)

_____ Mercy Health Partners (Western Hills, Mt. Airy, Anderson)

_____ Health Alliance (Jewish Kenwood, Christ, University, St. Luke's, Fort Hamilton)

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

_____ Drake Center

_____ Dearborn County Hospital

Area of interest/occupation you would like to observe: _____

****You will need to call your on-site contact to schedule your job shadowing date. Your facility contact will be given to you at orientation.**

Contact _____ **Phone** _____

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 record, 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 reserved after paperwork is received by 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? If no,

Yes NO I have had a recent exposure to chicken pox in 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 to the Health Council to receive an orientation date.**