



Dear Participant,

A job/career shadow experience gives students and/or adults considering changing careers a meaningful introduction to the world of healthcare. It helps the participant identify career interests and gives them an awareness of the academic, technical and personal skills required by particular jobs in the healthcare environment. The primary objective is to have the participant observe the technology and skills used every day on the job.

Enclosed is the required paperwork. Please complete and call Carol at 837-1627 or Elizabeth at 837-1628 to set up an interview. Once an interview date is established, bring your completed paperwork along with you driver's license, social security card and immunization record to the interview. The interview must be completed before a job/career shadow date is set. Please be aware that any placement of a volunteer/job shadow student can take up to three weeks or longer to complete so please take this into consideration when applying.

Thank you and enjoy your experience.

Sincerely,

**Carol Allen, CAVS
Director, Volunteer Services
Sunnyside Community Hospital**



Job Shadow Program

A job shadow experience gives students and/or adults considering changing careers a meaningful introduction to the world of healthcare. It helps the participant identify career interests and gives them an awareness of the academic, technical and personal skills required by particular jobs in the healthcare environment. The primary objective is to have the participant observe the knowledge and skills used every day on the job.

Program Requirements

Participants must be 15 years or older. A job shadow participation agreement form, WSP (Washington State Patrol request for criminal history, disclosure statement, medical release, parental consent form (if under 18) confidentiality agreement, and fire safety education must be completed prior to scheduled job shadow. Eight (8) hours or less if the maximum job shadow exposure. One job shadow experience per participant is encouraged.

Job Shadow Guidelines

Job shadow opportunities are limited and must receive prior approval through volunteer services and the requested department manager. Our patients' confidentiality, safety and care as well as the safety of the job shadow participant are our utmost concern. Therefore some departments may be restricted from a job shadow experience. Participants must wear appropriate clothing. Excessive jewelry and/or perfume are not allowed. Department managers may request specific attire be worn during the job shadow experience.

CONTACT: Sunnyside Community Hospital Volunteer Service Department

Carol Allen, Director, Volunteer Services

509-837-1627



Job Shadow Application Form

Name: _____ Date _____

Address: _____ Telephone: _____

C/S/Z _____ Over 15 years of Age: Y / N

Emergency Contact #1: _____ Telephone: _____

Relationship: _____

Address: _____

Emergency Contact #2: _____ Telephone: _____

Relationship: _____

Address: _____

Your Primary Care Physician: _____ Telephone: _____

Do you have any health problems or physical limitations? No Yes: _____

School: _____

Guidance Counselor or Teacher: _____

Year in School : _____ (i.e. Jr, Sr) School Phone: _____

Expected Graduation Date: _____

In what area of interest would you want to job shadow?

Department: _____ Please Explain: _____

Please list your top four choices for Job Shadow:

#1. _____

#2. _____

#3. _____

#4. _____

How much time do you wish to contribute to the job/career shadowing opportunity?

2 hours _____ 4 hours _____ 8 hours _____ Other _____

When are you available to job/career shadow?

	Su	M	T	W	T	F	Sa
AM							
PM							
EVE							

Do you know someone on staff at Sunnyside Hospital you would like to job shadow?

Name/Title: _____

Department: _____

Relationship: _____

Phone/Email: _____

Job/career shadows will occur as early as November and run through March. Due to the influx of students wishing to complete their job shadow experience by May and respecting your mentor's time, all assignments must be scheduled through Volunteer Services no later than March.

How did you learn about the Job/Career Shadow program? (Please circle)

School Counselor/Teacher Friend/Relative Brochure Website Other

Agreement

I understand that as a participant in the Sunnyside Community Hospital program, I can voluntarily end my services or be terminated at any time for any reason and no reason at all. I agree to get a job-related medical examination or have laboratory work completed if needed and authorize the examining medical provider to disclose the findings to the Hospital. If given opportunity to participate in a program, I will abide by the Hospital's Rules and Regulations, which I understand are subject to change.

I understand that all forms, examinations and orientation must be complete prior to my placement in a Hospital program. I will complete and turn a program evaluation form following my experience and documenting my hours to my school counselor/teacher.

Signature of Participant: _____ Date: _____

I have read, understood and agree to give permission for my son or daughter to participate in a Sunnyside Community Hospital program.

Signature of Parent/Guardian: _____ Date : _____

(Required if applicant is under the age of 18)



MEDICAL AUTHORIZATION FORM

PLEASE NOTE: To participate in a job/career shadow experience, this form must be filled out and returned to volunteer services prior to the job shadow date. Should it be necessary to receive medical treatment while participating in the job shadow program, I hereby give the hospital personnel permission to use their best judgment in obtaining medical service for me. Permission is also granted to render whatever medical treatment SCH deems necessary and appropriate.

PARTICIPANT'S NAME _____

ADDRESS _____

DATE OF BIRTH _____

HOME PHONE _____

PARENT/GUARDIAN (if under 18) _____

DAYTIME PHONE _____ CELL PHONE _____

PRIMARY CARE PHYSICIAN _____

PHONE _____

Do you require any special accommodations due to medical limitations, disability, dietary constraints or other restrictions?

Please explain _____

YES _____ I hereby agree to all the above authorization and permissions.

PARTICIPANT'S SIGNATURE _____ Date _____

SIGNATURE OF PARENT/GUARDIAN _____ Date _____

(Transportation/expenses incurred will be the responsibility of the parent/participant)



**EMPLOYEE HEALTH
NON-EMPLOYEE/VOLUNTEER REQUIREMENTS**

VOLUNTEER/OBSERVER NAME: _____

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____

PHONE NUMBER: _____

**IMMUNIZATION RECORDS WILL BE REQUIRED PRIOR TO PLACEMENT AND
REVIEWED BY INFECTION CONTROL**

TUBERCULOSIS EDUCATION:

Tuberculosis (TB) is an airborne communicable disease that is spread from person to person through the air. The germs are put into the air when a person with TB coughs, sneezes, laughs or sings. If another person inhales air containing these germs, transmission may occur. TB usually affects the lungs but can also affect other parts of the body, such as the brain, the kidneys or the spine.

General symptoms of TB may include feeling weak or sick, weight loss, fever and/or night sweats. Symptoms of the lungs may include cough, chest pain and/or coughing up blood.

About 10% of infected persons will develop TB disease at some time of their lives but the risk is considerably higher for persons who are immunosuppressed, especially those with HIV infection.

Volunteers, students and job shadows placed in areas of direct patient care or direct contact with the public will be required to have TB test. All other placements will be determined on a case by case basis, depending upon department placement. The TB test is available free of charge and must be administered 72 hours prior to first day of assignment. Please complete the following checklist:

- _____ Cough lasting more than two – three weeks
- _____ Coughing or spitting up blood
- _____ Chest Pain
- _____ Drenching night sweats of more than two weeks duration
- _____ Loss of appetite
- _____ Unexplained weight loss
- _____ **NONE OF THE ABOVE**

Volunteer/Job Shadow Name

Date

CONFIDENTIALITY

All job/career shadows have an ethical and legal duty to treat all patient information as confidential. It is the legal right of each patient to expect privacy regarding his or her care. This includes any information on a medical record, the computer system, overheard conversation or visual contact with a patient you may recognize.

HIPAA – Our Commitment To Do The Right Thing

HIPAA (Health Insurance Portability and Accountability Act of 1996) establishes guidelines about who can access patient information. Much of it is plain common sense. Access to certain information is dependent on what type of job you are doing. Some basics to keep in mind are:

- The mere fact that a person is in the hospital, is here for testing or seeing a doctor is confidential information.
- If information is overheard in passing, it must be kept in confidence.
- Do not access more information than is necessary to perform your duties.
- Patient information must be carefully guarded. *ALWAYS* keep papers containing patient information face down on the work surface to maintain confidentiality.
- Never throw paperwork that contains patient information in open trashcans. Always use approved containers as directed by your supervisor.
- There *ARE* penalties for noncompliance, which can include fines, criminal sanctions and even imprisonment in the most severe cases.





10th & Tacoma * P.O. Box 719 * Sunnyside, WA 98944
(509)837-1500 * Fax (509)837-1740

STATEMENT OF CONFIDENTIALITY

I, as an _____
(Employee, Volunteer, Staff Member, Board Member, Contract Employee, Student)

of Sunnyside Community Hospital & Clinics, understand that Washington State privacy laws and federal Health Insurance Portability and Accountability Act (HIPAA)/Health Information Technology and Clinical Health (HITECH) regulations, as well as the policies of this facility, prohibit the unauthorized disclosure of personal, demographic, patient insurance, financial, and medical information, including a patient's medical history, mental or physical condition, or treatment, **whether or not the information is contained in the patient's medical record.** I understand that unauthorized viewing of a patient's Protected Health Information (PHI), or viewing information without a legitimate **need to know**, is also prohibited. When there is a legitimate need to know PHI, I will disclose or ask for only the **minimum necessary** information for the situation. If I am a nurse (RN, LPN, NAC, NAC/HUC, MA or student), however, I may access all PHI on any patient I am directly treating. If I am aware of an inappropriate disclosure of a patient's PHI, or have a question or concern regarding a patient's privacy rights, I will notify the HIPAA Privacy Officer and/or the CEO.

I understand that I am not to access any patient records unless that patient has a valid clinical registration at the clinic or department where I am employed or stationed, and/or I have a job-related need to access it. I further understand that I am not to access my own patient record or that of an immediate family member. Our patient records are to be obtained by written request through Medical Records or the clinic where we are being treated.

I also understand that the law and the policies of this facility prohibit the accessing and disclosure of other confidential information, including but not limited to information about members of the medical staff, the facility's employees, and the facility's finances. I understand it is my duty and obligation to maintain confidentiality of all such information, and I shall do so throughout and after the tenure of my services at this facility.

I further understand that any accidental or intentional violation of confidentiality may lead to serious consequences, up to and including termination of my employment, discontinuance of my volunteer services at this facility, legal action, or other appropriate action as deemed necessary by the employer.

Name

Date

Signature

Witness

Date

DRESS CODE

This dress code is aimed for a polished professional appearance. All students are required to pay close attention to the following areas and dress accordingly. Any student not adhering to the dress code will be sent home.

Volunteers should always be careful in personal hygiene, neatness of attire, and cleanliness of apparel. Hair will be clean and net. Long hair needs to be pulled back away from face. Because many patients are highly sensitive to perfume, should be used in moderation. Gum chewing is not allowed.

- Blue denim jeans are not acceptable. Kakis or black pants must be worn.
- Zip-ups, hoodies, sweatshirts or any fleece clothing articles are not allowed.
- Shoes must be clean and with closed toes. Flip-flops and sandals are not allowed. Bare feet/legs are not acceptable. Socks/nylons must be worn with no bare leg showing.
- Facial piercings must be covered with a band aid or piercing jewelry removed.
- Hair will be clean and neat. Long hair should be pulled back away from the face.
- Your school name badge and a hospital name tag must be worn on a lanyard above the waist at all times.
- A lab coat will be provided if required by the department and worn with snaps closed.
- Scrubs will be acceptable per permission of the mentor.

The director of Volunteer Services has the right to determine whether a volunteer is inappropriately dressed for duty. The Director also has the right to request that the volunteer not report to their assigned position due to inappropriate dress.

EMERGENCY PROCEDURES

Emergency Codes:

Sunnyside Community Hospital has specific procedures to follow in the event of an internal or external emergency. "Codes" are paged overhead by the operators to alert those in the building of such situations. The following is a list of the emergency codes and their meanings.

<u>CODE</u>	<u>SITUATION</u>
CODE RED	Fire
CODE INTERNAL TRIAGE	Internal Disaster
CODE EXTERNAL	External Disaster
CODE GRAY	Combative Person
CODE SILVER	Weapon/ Hostage Situation
CODE ORANGE	Hazardous material Spill
CODE BLUE	Heart or Respiration Stopping
CODE AMBER	Infant/ Child Abductions

Bomb Threat:

A code is not announced; departments are notified to search the area.

If you answer the phone and receive a bomb threat, stay calm and observe the following steps.

- Listen carefully to what is being said and take notes on the Bomb Threat Record near your phone.
- Keep the person talking as long as possible and, if appropriate, get the attention of someone in your immediate area.

Bomb Threat (cont):

- Listen for distinguishing background noises such as music, voices, airplanes, church bells.
- Leave the receiver UNHOOKED when the caller hangs up.

Ask questions:

- Where is the bomb?
- When will it explode?
- Why are you targeting Sunnyside Community Hospital?

Listen to the caller's voice:

- Is it a man or woman?
- Are they nervous or calm?
- Are they young or old?
- Do you detect an accent or speech pattern?

FOR ANY EMERGENCY:

DIAL 911



FIRE SAFETY

As volunteers, you are extra hands and eyes to help us ensure the safety of our environment for patients, visitors and employees.

General Fire Facts:

- **Fire spreads very quickly. It takes less than three minutes to go from a small flame to a raging inferno.**
- **Heat from a fire poses a greater danger than the actual flames. Heat from fire rises, so the coolest place is near the floor.**
- **Smoke also poses tremendous danger. Smoke contains toxic gases that can cause death in just a few minutes. Smoke, like heat, rises. The least amount of smoke will be near the floor. If you must enter a smoke-filled room, crawl on your hands and knees.**

When a “Code Red” is called, remember **R A C E**

Rescue	Rescue anyone in danger of flames or smoke
Activate	Activate alarm. Call 1706 and report location
Contain	Close all doors and windows
Evacuate	Evacuate

Remember to dial 911 on an outside line for outlying buildings and parking lots.

If you hear code Red – Close all doors and windows and report to main parking lot and sign in.

Use of Extinguisher:

P A S S

Pull	- pin
Aim	- Nozzle
Squeeze	- Handle
Sweep	- From side to side

Volunteers play an important role by serving as support and by remaining alert to conditions in their environment.

FIRE SAFETY (CONT.)

Prepare for the unexpected during a fire:

If your clothes catch on fire, remember the following:

- **STOP** – where you are
- **DROP** – to the floor
- **ROLL** – around on the floor





STUDENT EVALUATION

(To be completed by mentor)

Student: Please fill out the top three lines and give the form to the staff member you are assigned to at Sunnyside Community Hospital. Ask them to complete this form and return it to Carol Allen in Volunteers Services by Inter-Office mail.

Student Name: _____

School/Year: _____

Date/Time/Length of Experience: _____

Sunnyside Community Hospital Staff Member

Please fill out this evaluation of the student named above based on the criteria below and return it to Carol Allen in Volunteer Services by Inter-Office mail. Thank you for your time and assistance with our Job Shadow Program.

Employee Name: _____

Job Title and Department: _____

Criteria: 1 = Needs Improvement, 2 = Acceptable, 3 = Good, 4 = Excellent

Student was respectful of all patient rights	1	2	3	4	N/A
Student interacted appropriately with patients	1	2	3	4	N/A
Student demonstrated compassion in all interactions	1	2	3	4	N/A
Student behaved professionally at all times	1	2	3	4	N/A
Student was appropriately dressed	1	2	3	4	N/A
Student seemed prepared for experience	1	2	3	4	N/A
Student remained attentive during experience	1	2	3	4	N/A
Student asked appropriate questions at appropriate times and places	1	2	3	4	N/A
Student demonstrated flexibility in response to ongoing activity	1	2	3	4	N/A
Student reflected appropriate atmosphere and attitude in all encounters	1	2	3	4	N/A
Student readily accepted direction and guidance	1	2	3	4	N/A

Other comments? Please share:



JOB/CAREER SHADOW
(to be completed by the student)

EVALUATION

Facility:

- Sunnyside Community Hospital
- Sunnyside Community Hospital _____ Clinic

Student Name: _____

Department Name: _____

Person Shadowed: _____

1. Please provide a brief explanation as to why you requested this job shadow.

2. Did this job shadow experience interest you in pursuing a career in this PARTICULAR DEPARTMENT?

**YES
WHY?**

**NO
WHY NOT?**

3. Please answer the following regarding your job shadow experience.

- a. The department was interesting. Yes___No___
- b. The staff was courteous and informative. Yes___No___
- c. This experience is a valuable tool. It has influenced my decision to pursue a career in health care. Yes___No___

Please note below any comments and/or suggestions you may have regarding this or future JOB SHADOWS. Please keep in mind that your name WILL NOT be used in any way, so all comments and suggestions will remain anonymous.