

## **Tomah Health Job Shadow Application and Agreement Information**

Welcome! To ensure that you get maximum benefit from your Job Shadowing experience, there are several topics we think you should know about.

**CONFIDENTIALITY:** The nature of the health care industry and the state and federal privacy laws require all job shadows to maintain a high level of confidentiality. All medical and business information is confidential. **Under no circumstances will such information be discussed with any unauthorized person(s) either outside or inside of the health care facility.** To engage in discussions of confidential information is a breach of privacy and may lead to legal consequences.

**INFECTION PREVENTION:** Proper hand washing helps to prevent the spread of infections from one person to another. Hand washing products, are available in the rest rooms and work areas.

You may not enter any room designated “Isolation”. If there is a potential that you will have direct contact with a patient’s blood or other body fluids, you **must** wear personal protective equipment

**GENERAL SAFETY:** The overhead paging system will announce safety alerts. Stay with your designated preceptor for more instruction.

**SMOKING:** Tomah Health is a tobacco free healthcare facility.

**DRESS CODE:** You will be instructed on the appropriate work attire for your requested job shadow area.

**HEALTH REQUIREMENTS:** All health requirements, as listed on the application, must be completed before job shadowing. This includes TB screening, two dates of MMR, Varicella immune status by titer or 2 vaccines, Covid-19 Vaccination and Influenza Vaccination information if shadowing between October and April.

**MISCELLANEOUS INFORMATION:** If you are unable to report for your scheduled job shadow experience, please notify the assigned department manager or the HR department.

Job Shadow Agreement must be signed.

**Tomah Health  
JOB SHADOW APPLICATION**

*Please turn in this completed form, along with the signed Job Shadow Agreement and Influenza form (if applicable), at least two weeks prior to your requested Job Shadow date.*

Student Name: \_\_\_\_\_ School: \_\_\_\_\_  
 Address: \_\_\_\_\_ Grade: \_\_\_\_\_  
 City: \_\_\_\_\_ School Contact: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
 Age: \_\_\_\_\_ DOB \_\_\_\_\_  
 Email address: \_\_\_\_\_

Parent Name: \_\_\_\_\_  
 Emergency Contact Number: \_\_\_\_\_

Preferred days to take part in a job shadow experience. Select all that apply or list dates:  
 Monday  Tuesday  Wednesday  Thursday  Friday \_\_\_\_\_

Department(s) Requested: \_\_\_\_\_ or

Career Interest or unit: \_\_\_\_\_

Name of person you would like to shadow (if known): \_\_\_\_\_

**Job Shadow Application Health Screening:                      PERSONAL HEALTH HISTORY**

<b>Immunizations</b> (must attach copies of all immunizations)
Hepatitis B x3 vaccine dates <i>or</i> titer date:
Influenza vaccine date (October-April):
Measles, Mumps, & Rubella (MMR) x2 vaccine dates or titer date:
SARS COVID-19 vaccine date:
Tetanus, Diphtheria and Pertussis (Tdap) vaccine date:
Tuberculosis skin test or blood draw date (within last 12mos):
Varicella x2 vaccine dates or titer date:

1. Do you have any major medical problems that we should be aware of? Yes No If yes explain,  
 \_\_\_\_\_

I certify the health history requirements are true and complete.

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

**CONTINUED ON BACK**

**JOB SHADOW APPLICATION** (continued)

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**OFFICE USE ONLY – DO NOT WRITE BELOW THIS LINE**

Health history reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

Mentor: \_\_\_\_\_

Mentor scheduled for date / time: \_\_\_\_\_

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**Thank you for taking the time to complete this application.** We are eager to introduce you to rewarding careers in rural healthcare! We will review your application and do our best to match you with an appropriate mentor. All sections of this application must be completed prior to your job-shadowing experience. Please return this application to:

**Tomah Health Human Resources**  
**Attn: Kasey Bloom**  
501 Gopher Drive, Tomah, WI 54660  
PH: (608) 377-8311  
FAX: (608) 377-8729

**PLEASE READ THIS SECTION CAREFULLY BEFORE SIGNING**  
(If a minor, a parent or legal guardian's signature is mandatory)

**Job Shadow Agreement**

1. I, have requested to be present in the hospital, clinic, or hospice.  
I, the Job Shadow Participant, agree to adhere to the following rules:
  - a. Read Tomah Health's job shadow application and agreement information and adhere to the information I will ask questions if I do not understand the information.
  - b. Follow good hand-washing techniques
  - c. Adhere to the job shadow dress code
  - d. Wear personal protective equipment if there is a potential of contacting blood or other body fluids
  - e. Wear a name tag identifying myself as a Job Shadow
  - f. Inform my mentor if at any time I feel ill during the shadowing activity
  - g. Arrive promptly and remain flexible to allow for extenuating circumstances such as patient emergencies that might interrupt the schedule
  - h. Remain at all times where directed and leave the areas when requested to do so by a physician, nurse, or administration
  - i. At the conclusion of my assignment, complete an evaluation of the program and return to HR.
2. I understand the patient's right to confidentiality and agree to respect that right by not disclosing information regarding any patient or regarding the organization/administration.
3. I understand this permission may be revoked at any time during the observation period by the attending physician or other staff.
4. In consideration of the permission granted, I hereby release the physicians, the organization, and its employees from any claims or liability, physical injury and/or damage including emotional distress or injury or mental anguish which may be sustained by me as a result of the presence of myself in the hospital, clinic, or hospice setting.
5. I am age 15-17 years of age with parental/guardian consent or am over the age of 18

**SIGNED BY:**

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature of Parent/Guardian of Minor *(required if under 18)*

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

**Tomah Health  
Evaluation For  
JOB SHADOW PARTICIPANTS**

Please take a few minutes to complete the following evaluation. Your responses will help us improve our job shadow program.

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Please rate the following: (5 = Agree very much to 1= Disagree Very Much)

- |   |   |   |   |   |   |
|---|---|---|---|---|---|
| 1. I learned more about career opportunities in the rural healthcare setting from this experience.        | 5 | 4 | 3 | 2 | 1 |
| 2. My experience shed a positive light on the job I shadowed.   | 5 | 4 | 3 | 2 | 1 |
| 3. My mentor made me feel welcome.  | 5 | 4 | 3 | 2 | 1 |
| 4. My mentor was helpful by explaining things and answering my questions.                                 | 5 | 4 | 3 | 2 | 1 |
| 5. As a result of my experience I am <u>more</u> likely to pursue a career in healthcare.                 | 5 | 4 | 3 | 2 | 1 |
| 6. I would recommend this program to others who would like to learn more about the healthcare profession. | 5 | 4 | 3 | 2 | 1 |
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What did you like most about your job shadow experience?

What did you like least about your job shadow experience?

Please return this evaluation to your mentor in the provided, sealed envelope to forward to Human Resources. Thank you for taking part in our program.