Lima Memorial
HEALTH SYSTEM

Job Shadow Application

Today's Date:_____/_____/_____

ALL APPLICANTS MUST COMPLY WITH LIMA MEMORIAL DRESS CODE AND HIPAA POLICIES
DRESS CODE IS BUSINESS CASUAL OR SCRUBS (NO JEANS), AND PLEASE WEAR COMFORTABLE SHOES.

Please return completed forms to jobshadow@limamemorial.org

Please select one of the following:

☐ Job Shadow - High School ☐ Job Shadow – College/University ☐ Job Shadow – Other

High School_____ College/University_____ Other_____

Is job shadowing a requirement in order to graduate? Please circle: **Yes** **No**

How did you hear about us? *(Please indicate one of the following):*

☐ School ☐ Friend ☐ Family member works at Lima Memorial ☐ Online

☐ Other – Please specify: _____

Applicant Information (Please print)

Name_____ **Address**_____

Phone # (_____**)**_____**-**_____ **City**_____ **State**_____ **Zip**_____

Email_____ **Age** _____ ***(only for HS students)***

Areas of Interest/Availability

(You must be 16 years or older to shadow in Surgery, OB, Laboratory, and ICU)

☐ Laboratory ☐ Patient Care ☐ Pharmacy ☐ Physicians ☐ Radiology ☐ Respiratory ☐ Surgery ☐ Therapy

☐ Business – Please specify: _____ ☐ Nursing – Please specify dept.:_____

Preferred Time & Day to Shadow

☐ Morning - Hours Available_____ ☐ Monday ☐ Tuesday ☐ Wednesday

☐ Afternoon - Hours Available_____ ☐ Thursday ☐ Friday

☐ Evening - Hours Available_____ ☐ Specific dates_____

FOR HR USE ONLY

☐ Job Shadow Application Received
☐ TB Received
☐ Consent forms signed
☐ Emailed department manager
☐ Manager/associate approved
☐ Calendar Invite sent to manager
☐ Confirmation sent to job shadow

Date(s) scheduled:_____/_____/_____ **Time(s) scheduled:** _____

Department: Associate Contact: EXT #:

Lima Memorial
HEALTH SYSTEM

Affiliate of ProMedica

Lima Memorial Health System

Tuberculosis Questionnaire

Name (Please print):_____Date: _____

Signature:_____D.O.B.: _____

CURRENT SYMPTOMS

1. Do you have a cough that has lasted longer than three weeks?

- ☐ Yes
- ☐ No

2. Do you cough up blood or mucous?

- ☐ Yes
- ☐ No

3. Have you lost your appetite? Aren't hungry?

- ☐ Yes
- ☐ No

4. Have you lost weight (more than 10 pounds) in the last two months, without trying to?

- ☐ Yes
- ☐ No

5. Do you have night sweats (need to change the sheets or your clothes because they are wet)?

- ☐ Yes
- ☐ No

TB HISTORY

1. Have you ever had a positive TB skin test?

- ☐ Yes
- ☐ No
- ☐ Don't know

2. Have you ever had an abnormal chest x-ray?

- ☐ Yes
- ☐ No

If yes, how long ago?

3. Have you recently had the mucous you cough up tested for TB?

- ☐ Yes
- ☐ No
- ☐ Don't know

If yes, were you told it was positive?

- ☐ Yes
- ☐ No

4. Have you ever been told you have Infectious Tuberculosis?

- ☐ Yes
- ☐ No

If yes, how long ago?

5. Have you ever been treated with medication for Infectious TB?

- ☐ Yes
- ☐ No

If yes, how many medications?

- ☐ One
- ☐ Two
- ☐ More than three

6. **Are you still taking TB medicine?**

- ☐ Yes
- ☐ No

Did you take all the TB medicine until the health care professional told you that you were finished?

- ☐ Yes
- ☐ No

7. **Do you live with or have you been in close contact with someone who was recently diagnosed with TB? (e.g. shelter roommate, close friend, relative).**

- ☐ Yes
- ☐ No
- ☐ Don't know

Lima Memorial
HEALTH SYSTEM

Student name: _____

Confidentiality

Associates, students, clinical site staff, and, most importantly, patients, deserve and expect confidentiality. It is a Health System standard to treat all aspects of a student's education and practice experiences as protected information. All practice settings must take reasonable steps to limit protected health information (PHI) as required by the Federal HIPAA law. This includes familiarizing the students with their policies and procedures related to PHI. NO INFORMATION THAT IDENTIFIES PATIENTS AND THEIR CONDITIONS IS TO BE DISCUSSED OUTSIDE OF AN EDUCATIONAL CONTEXT. It is acceptable for a specific case to be discussed for an academic case study presentation; however, every precaution must be taken to protect the patient's right to privacy.

Personal Cell Phone Use

Cell phones should be turned off and stowed out of the way during clinical experiences. Cell phones are not permitted to be used during clinical experiences unless otherwise directed by an instructor or clinical staff member.

I understand and I agree to abide by the above policies:

_____

Student Signature and Date

ACTIVITY RELEASE FORM

This form is to be completed by all individuals attending Lima Memorial Health System for events. This form should be completed by participants prior to the activity. Signed forms will be kept by the person/department in charge of the activity.

Name of Individual

The individual signed below voluntarily desires to participate in the following activity:

Name of Activity

The individual is aware of the risks and hazards which may arise through participation in this activity and that participation in this activity may result in loss of life and/or limb and/or property of the student. It is agreed that in consideration of participating in this activity and receiving educational and other benefits from the activity the individual voluntarily assumes all risks of accident or personal damage to his or her property and releases Lima Memorial Health System, it's agents, and employees form any claim, liability, or demand of any kind sustained, whether caused by negligence of the aforementioned system, their agents, employees, or otherwise. The release shall be binding upon any heirs, administrators, executors, and assigns of the undersigned.

It is also understood that if medical treatment is deemed necessary, all financial responsibility be that of the undersigned and not that of Lima Memorial Health System. By signing this agreement, you accept all financial responsibility of medical services provided at Lima Memorial Health System.

_____ _____

Date Individual's Signature

_____ _____

Date Legal Guardian/Parent Signature (if under 18 years)