Doctors Hospital
Job Shadow/Observer Program

Overview

Program participants will have the opportunity to see, firsthand, the healthcare workplace and the day-to-day work of professionals in the healthcare field during their experience. This program at Doctors Hospital provides experiential learning opportunities designed to help individuals learn about health career options as well as the skills that different occupations require.

Our MISSION - Above all else we are committed to the care and improvement of human life.

The goals of this program are to assist participants in accomplishing the following:

- Completing required components of high school or college project or curriculum
- Observe the daily routines of healthcare workers
- Begin to identify career interests in healthcare
- Gain awareness of the academic, technical and personal skills required in healthcare professions
- Gain an understanding that different health careers have cultures and work environments that can be unique to a particular profession
- Develop an understanding of the critical connections between school, work and goal attainment

This program allows for an experience for a maximum of 8 hours (1 days). **Requests for observation experiences greater than 8 hours are considered formal student placements and require a current Education Affiliation Agreement between the education program and the facility.**

The minimum age to participate in the program is **16 years of age** and is available to high school juniors/seniors or college students requiring observation as part of their school curriculum. Special permission may be granted in limited circumstances for individuals requesting observation for exploring a first or second career.

Labor and Delivery, NICU, Mom/Baby, Oncology, Behavioral Health and Pediatrics **do not** allow observers for the protection of our patients and staff unless special permission is granted.

We hope that your time with us will be an enjoyable and educational experience.

Instructions

To ensure that you are properly registered to participate in this program at Doctors Hospital, please carefully follow the instructions outlined below. The application process consists of these steps:

1. Complete all documentation required from ***school and/or student:***
   (Please allow 2 - 4 weeks for processing and placement)

   - ☐ Application
   - ☐ State issued ID. Original document must be presented to Human Resources representative
   - ☐ Copy of flu vaccination if shadow is between October 1st and March 31st
   - ☐ Confidentiality and Security Agreement
   - ☐ Observer Waiver and Release
   - ☐ Parking and Proxy Form
   - ☐ Evaluation – After experience completed and badge is turned in

2. Mail or email all forms to:

   Doctors Hospital of Augusta
   Human Resources Department
   Attn: Tiffany Williams
   3651 Wheeler Road
   Augusta, GA 30909

   Email: tiffany.williams3@hcahealthcare.com
   Phone: (706) 651-2400

3. You will be notified via email once a placement in your specified area is secured and has been approved. **Response time for this process may vary depending on the department's availability and program demands. Please allow up to four weeks for processing and placement.**

4. Report to the hospital's Human Resources Department on the day of your experience to receive your temporary Identification Badge. This badge MUST be returned to the Human Resources Department at the completion of the observation experience.

5. Once your experience is complete, please return the Evaluation Form regarding your experience. You may mail or email this evaluation to Human Resources.

Job Shadow/Observer Program | 2021

Application

Name:_____ **Email Address:**_____

Address: _____

Phone:_____ **Date of Birth:** _____

High School or College Name currently enrolled in: _____

Emergency Contact Name and Number: _____

Available Date: _____

Is this request to shadow for a high school or college curriculum requirement? _____

What is your goal or objective for this shadow? _____

_____

_____

_____

_____

_____

Department or Individual you are requesting for your job shadow experience: _____

Shadow Signature:_____**Date:** _____

Parent Signature (If Under 18):_____**Date:** _____

If you are requesting to observe a physician or mid-level please obtain their signature indicating approval below.

Department Director and Physician or Mid-level responsibilities:

Assure that patient permission for non employee observation is obtained prior to each encounter.

Ensure that all observers are accompanied by a Doctors Hospital employee or affiliated physician during entire observation experience.

For OR observations patient consent must be noted on the consent form.

Physician or Mid-level approval:_____**Date:**_____

Doctors Hospital Staff Only

Human Resources:_____**Date:**_____

Department Director:_____**Date:**_____

Confidentiality and Security Agreement

I understand that the HCA affiliated entity(ies) (the "Company") for which I am a Workforce Member (my "Engagement") manages health information and has legal and ethical responsibilities to safeguard the privacy of its patients and their personal and health information ("Patient Information"). "Workforce Member" means employees, employed Licensed Independent Practitioners (LIPs) (e.g., employed/managed physicians), employed Advanced Practice Professionals (APPs), residents/fellows, students (e.g., nursing, medical, and interns), faculty/instructors, contractors (e.g., HealthTrust Workforce Solutions (HWS), travelers, network/per diem staff, or dependent healthcare professionals and/or contracted through another temporary staffing agency), and volunteers.

Additionally, the Company must protect its interest in, and the confidentiality of, any information it maintains or has access to, including, but not limited to, financial information, marketing information, Human Resource Information, (as defined below), payroll, business plans, projections, sales figures, pricing information, budgets, credit card or other financial account numbers, customer and supplier identities and characteristics, sponsored research, processes, schematics, formulas, trade secrets, innovations, discoveries, data, dictionaries, models, organizational structure and operations information, strategies, forecasts, analyses, credentialing information, Social Security numbers, passwords, PINs, and encryption keys (collectively, with patients' information, "Confidential Information"). The Company must also protect Company Property (such as inventions, software, trade secrets, and Developments (as defined below)).

During the course of my Engagement with the Company, I understand that I may access, use, or create Confidential Information. I agree that I will access and use Confidential Information only when it is necessary to perform my job-related duties and in accordance with the Company's policies and procedures, including, without limitation, its Privacy and Security Policies (available at http://hcahealthcare.com/ethics-compliance/ and the Information Protection Page of the Company's intranet). I further acknowledge that I must comply with such policies, procedures, and this Confidentiality and Security Agreement (the "Agreement") at all times as a condition of my Engagement and in order to obtain authorization for access to Confidential Information and/or Company systems. I acknowledge that the Company is relying on such compliance and the representations, terms and conditions stated herein.

GENERAL

1. I will act in the best interest of the Company and, to the extent subject to it, in accordance with its Code of Conduct at all times during my Engagement with the Company.
2. I have no expectation of privacy when using Company systems and/or devices. The Company may log, access, review, and otherwise utilize information stored on or passing through its systems, devices and network, including email.
3. Any violation of this Agreement may result in the loss of my access to Confidential Information and/or Company systems, or other disciplinary and/or legal action, including, without limitation, suspension, loss of privileges, and/or termination of my Engagement with the Company, at Company's sole discretion in accordance with its policies.

PATIENT INFORMATION

4. I will access and use Patient Information only for patients whose information I need to perform my assigned job duties in accordance with the HIPAA Privacy and Security Rules (45 CFR Parts 160—164), applicable state and international laws (e.g., the European Union General Data Protection Regulation), and applicable Company policies and procedures, including, without limitation, its Privacy and Security Policies (available at http://hcahealthcare.com/ethics-compliance/ and the Information Protection Page of the Company's intranet).
5. I will only access, request and disclose the minimum amount of Patient Information needed to carry out my assigned job duties or as needed for treatment purposes.
6. By accessing or attempting to access Patient Information, I represent to the Company at the time of access that I have the requisite job-related need to know and to access the Patient Information.

PROTECTING CONFIDENTIAL INFORMATION

7. I acknowledge that the Company is the exclusive owner of all right, title and interest in and to Confidential Information, including any derivatives thereof.
8. I will not publish, disclose or discuss any Confidential Information (a) with others, including coworkers, peers, friends or family, who do not have a need to know it, or (b) by using communication methods I am not specifically authorized to use, including personal email, Internet sites, Internet blogs or social media sites.
9. I will not take any form of media or documentation containing Confidential Information from Company premises unless specifically authorized to do so as part of my job and in accordance with Company policies.
10. I will not transmit Confidential Information outside the Company network unless I am specifically authorized to do so as 1/2018 part of my job responsibilities. If I am authorized to transmit Confidential Information outside of the Company, I will ensure that the information is encrypted according to Company Information Security Standards and ensure that I have complied with the External Data Release policy and other applicable Company privacy policies.
11. I will not retain Confidential Information longer than required by the Company's Record Retention policy.

12. I will only reuse or destroy media in accordance with the Company's Information Security Standards.
13. I acknowledge that in the course of performing my job responsibilities I may have access to human resource information which may include compensation, age, sex, race, religion, national origin, disability status, medical information, criminal history, personal identification numbers, addresses, telephone numbers, financial and education information (collectively, "Human Resource Information"). I understand that I am allowed to discuss any Human Resource Information about myself and other employees if they self-disclose their information. I can also discuss Human Resource Information that does not relate to my individual employment or my job responsibilities and that is not in violation of any other provision in this Agreement.

USING MOBILE DEVICES, PORTABLE DEVICES ABD REMOVABLE MEDIA

14. I will not copy, transfer, photograph, or store Confidential Information on any mobile devices, portable devices or removable media, such as laptops, smart phones, tablets, CDs, thumb drives, external hard drives, unless specifically required and authorized to do so as part of my Engagement with the Company.
15. I understand that any mobile device (smart phone, tablet, or similar device) that synchronizes Company data (e.g., Company email) may contain Confidential Information and as a result, must be protected as required by Company Information Security Standards.

DOING MY PART – PERSONAL SECURITY

16. I will only access or use systems or devices I am authorized to access, and will not demonstrate the operation or function of systems or devices to unauthorized individuals.
17. I will not attempt to bypass Company security controls.
18. I understand that I will be assigned a unique identifier (i.e., 3-4 User ID) to track my access and use of Company systems and that the identifier is associated with my personal data provided as part of the initial and/or periodic credentialing and/or employment verification.
19. In connection with my Engagement, I will never:
    a. disclose or share user credentials (e.g., password, SecurID card, Tap n Go badge, etc.), PINs, access codes, badges, or door lock codes;
    b. use another individual's, or allow another individual to use my, user credentials (e.g., 3-4 User ID and password, SecurID card, Tap n Go badge, etc.) to access or use a Company computer system or device;
    c. allow a non-authorized individual to access a secured area (e.g,. hold the door open, share badge or door lock codes, and/or prop the door open);
    d. use tools or techniques to break, circumvent or exploit security measures;
    e. connects unauthorized systems or devices to the Company network; or
    f. use software that has not been licensed and approved by the Company.
20. I will practice good workstation security measures such as locking up media when not in use, using screen savers with passwords, positioning screens away from public view, and physically securing workstations while traveling and working remotely.
21. I will immediately notify my manager, Facility Information Security Official (FISO), Director of Information Security Assurance (DISA), Facility Privacy Official (FPO), Ethics and Compliance Officer (ECO), or Facility or Corporate Client Support Services (CSS) help desk or if involving the United Kingdom, the Data Protection Officer (DPO), Information Governance Manager, Caldicott Guardian, Heads of Governance (HoG), Division Chief Information Security Officer (CISO) if:
    a. my user credentials have been seen, disclosed, lost, stolen, or otherwise compromised;
    b. I suspect media with Confidential Information has been lost or stolen;
    c. I suspect a virus or malware infection on any system;
    d. I become aware of any activity that violates this Agreement or any Company privacy or security policies; or e. I become aware of any other incident that could possibly have any adverse impact on Confidential Information or Company systems.

UPON SEPARATION

22. I agree that my obligations under this Agreement will continue after termination or expiration of my access to Company systems and Company Information.
23. At the end of my Engagement with the Company for any reason, I will immediately:
    a. securely return to the Company any Confidential Information, Company related documents or records, and Company 1/2018 owned media (e.g., smart phones, tablets, CDs, thumb drives, external hard drives, etc.). I will not keep any copies of Confidential Information in any format, including electronic; and
    b. un-enroll any non-Company owned devices from the Company Enterprise Mobility Management System, if applicable.

EXCEPT TO THE EXTENT OTHERWISR AGREED IN A SEPARATE AGREEMENT, THE FOLLOWING STATEMENT APPLY TO ALL WORKFORCE MEMBERS

24. I shall promptly disclose to the Company all Company Property that I develop during my Engagement. "Company Property" means any subject

matter (including inventions, improvements, designs, original works of authorship, formulas, processes, compositions of matter, software, databases, confidential information and trade secrets), whether belonging to the Company or others, that, directly or indirectly: (i) I author, make, conceive, first reduce to practice, or otherwise create or develop, whether alone or with others using any Company equipment, supplies, facilities, or Confidential Information, or (ii) otherwise arises from work performed by me for the Company, its employees, or agents, (each of the foregoing, a "Development").

25. As between me and the Company, all Company Property is the property of the Company or its designee, and all copyrightable Developments that I create within the scope of my employment are "works made for hire."

26. I agree to assign, and do hereby irrevocably assign, to the Company or its designee all of my right, title, and interest in and to any and all Developments, together with all intellectual property and other proprietary rights therein or arising therefrom, including any registrations or applications to register such rights and the right to sue for past, present, or future infringements or misappropriations thereof.

27. During and after my Engagement, I agree to execute any document and perform any act to effectuate, perfect, enforce, and defend the Company's rights in any Development. I hereby appoint the Company and its authorized agent(s) as my attorney in fact to execute such documents in my name for these purposes, which power of attorney shall be coupled with an interest and shall be irrevocable, if I fail to execute any such document within five (5) business days.

28. If there is a conflict between a term in Sections 24 through 28 and a term separately agreed to in writing with the Company, the term set forth in the separate agreement will control.

By signing this document, I acknowledge that I have read and understand this Agreement, and I agree to be bound by and comply with all the representations, terms and conditions stated herein.

Employee/Student/Consultant/Vendor/Office Staff/Physician Signature: _____

Employee/Student/Consultant/Vendor/Office Staff/Physician Printed Name: _____

Facility Name and COID: Doctors Hospital – 31003
Business Entity Name: Doctors Hospital

Date: _____

Updated: 1/2018

Observer Waiver and Release

I _____, as an observer at Doctors Hospital, in consideration for being permitted to observe the staff perform direct patient care or observe other hospital operations in otherwise restricted areas of Doctors Hospital and all its employees, agents, and servants of and from any and all liability, claims and demands of any kind whatsoever arising in any way out of my observer activities at Doctors Hospital.

I further agree and stipulate that I will obey all direction and requests made to me by Doctors Hospital employees and physicians, and understand my presence within the Hospital is condition upon my obeying all directions and request made to me.

I agree that I will keep all patient information confidential and will not discuss patient information with any third party outside of the hospital. I also agree that if I am asked to leave the hospital, for any reason, I will remove myself immediately and without question.

I understand that I must be accompanied by a member of the Doctors Hospital staff or physician with privileges at Doctors Hospital at all times in the clinical environment.

Preferred Observation Dates:		
Preferred Observation Times:		
Preferred Observation Area / Department:		
Specific Person to follow if known:	Name:	
Observer Name:	Date:	Signature:
Parent (If Under 18) Name:	Date:	Signature:

General Information

HIPAA

Observers have an important role in complying with the Health Insurance Portability and Accountability Act (HIPAA). Patients are not to be discussed in public areas like the cafeteria, hallways or elevators. If there is a breach of confidentiality, the observer will be dismissed from the clinical setting.

What is HIPAA? Health Insurance Portability and Accountability Act of 1996. It's a federal law and mandatory!

The purpose is to reduce fraud and abuse and improve quality of healthcare in general.

What can happen when protected health information is inadvertently exposed? Personal harm to individuals, embarrassment, and community mistrust, lawsuits, etc. Privacy of patient information is a basic right.

Protected Health Information

✓ Protected Health Information (PHI) is about patient information - whether it is spoken, written, or on the computer. It includes health information about our patients. It can be information as simple as their name.

Certainly, we can share PHI when it is part of our job to do so, but beyond that you may have broken the law if you share patient information.

Parking

You may park in hospital visitor parking on the day of your job shadow.

Smoking

We are a smoke-free facility. Smoking is not permitted in the buildings or on the grounds.

Safety Information

- Code Red_____Fire
- Code Blue_____Cardiac or Respiratory Arrest
- Code Orange_____Hazardous Material Release
- Code Black_____Bomb Threat
- Code Pink_____Infant or Child Abduction
- Active Shooter_____ Active Shooter
- Code Green_____Severe Weather

MSDS

Each department has a copy that contains a department chemical inventory and Materials safety data Sheets (MSDS). MSDS is a chemical product information sheet that lists common names, hazards, exposure limits, precautions and first aid procedures.

Dress Code

Students/observers will adhere to our dress code policy and wear appropriate uniform/dress and identification. Doctors Hospital dress code guidelines include but are not limited to:

Hair/Nails

- Clean and well-groomed hair is expected.
- False fingernails are not permitted in direct patient care areas.

Jewelry/Cosmetics

- Jewelry should be professional in appearance and should not be excessive or be such that it may cause a safety issue with equipment.
- Heavy use of makeup, lotions, perfumes, colognes, and after shaves is not acceptable.
- Heavy scent of tobacco, perfumes and other products is not acceptable.

Clothing

- Professional or business clothing is expected.
- Sandals are not acceptable.
- Visible tattoos must be covered up.

Unacceptable dress options include, but are not limited to:

- Sleeveless garments (unless covered by a jacket or sweater)
- Shorts
- Tops that bare the midriff
- Denim
- T-shirts, sweatshirts, or any item with any logo that is not approved

Personal Communication and entertainment equipment:

- Personal cell phones must be on vibrate.
- Personal headphone radios or other such devices are not allowed. These devices must not interfere with communications or response to safety announcements.

FAQ

What do I do with my purse, cell phone, or backpack while I am shadowing?
Please lock these items inyour car trunk. Do not bring large amounts of cash, books, journals, etc.

I am younger than 18, do my parents sign the Application Form?

Yes. If you are under 18, your parent(s) or legal guardian(s) must sign the Job Shadow Application Form and Waiver Form in order for you to participate.

How far in advance should I submit my Job Shadow Registration Form?

All required paperwork should be submitted at least four weeks prior to the date in which you would like to shadow. We will attempt to meet your first choice for attendance.

I have been scheduled to Job Shadow and I seem to be coming down with a cold. What should I do?

Because patient safety is our number one priority, no unhealthy person will be permitted to participate in the Job Shadow Program. Should you become ill prior to your scheduled Job Shadow experience, please contact the Human Resources Department via phone or email. You will receive priority placement in the same area once you are healthy. Participants who arrive for their Job Shadow experience symptomatic will not be permitted to participate.

What should I do if I come down with Covid, Chicken Pox, Measles, or some other communicable disease within 48 hours after participating in the Job Shadow Program?

If you develop Covid, Chicken Pox, Measles, high fever or some other communicable disease within 48 hours after your Job Shadow experience it is very important that you contact Human Resources immediately (be sure toinclude your name and phone number). This will allow us to contact the appropriate individuals in an effort to prevent a potentially harmful outbreak that would threaten the health of our patients as well as our healthcare workers.

Evaluation

Please fill out this evaluation of your experience and give it to the Education Department following your experience. Your feedback helps us improve this program!

Preceptor Name: _____

Department:_____**Dates Observed:** _____

1 = Not At All/Poor, 2 = Acceptable, 3 = Good, 4 = Excellent/Absolutely

1. Did you enjoy your experience?	1 2 3 4
2. Did you learn about the healthcare field and hospital?	1 2 3 4
3. Was your assigned employee helpful?	1 2 3 4
4. I would recommend this program to others	1 2 3 4
5. If I had questions they were answered completely and politely.	1 2 3 4
6. I would rate my overall experience as:	1 2 3 4
7. Suggestions for how our hospital can improve your experience:	
8. Summary of your experience:	