Shadow Experience Agreement

ECU HEALTH

Shadow Applicant Information

Shadowing is a health service delivery observational experience by an individual that is short in duration *(not to exceed three consecutive weeks)* and is not being used to meet the requirements of an approved or organizational program such as those under student practicum/internship status.

First Name: _____ Middle Initial: ____ Last Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Home Phone: _____ (###) ###-#### Cell Phone: _____ (###) ###-####

Are you 18 years or older? Yes: ☐ NO: ☐ **If under 18, Name of Parent/guardian and contact information required:**

Parent/guardian Name: _____ Phone Number: _____ (###) ###-####

Address if different from Applicant: _____

Additional Shadow Applicant Information

Are you currently an ECU Health team member? Yes: ☐ No: ☐ If yes, team member ID#: _____

Are you currently an ECU Health VolunTEEN or Volunteer? Yes: ☐ No: ☐ If yes, what role/area: _____

"Current" Education Status: In High School: ☐ In College: ☐ (If checked, enter name of college): _____

In Nursing School? ☐ In Allied Health Program? ☐ Applying to advanced or graduate programs? ☐

Exploring healthcare, but not in school: ☐

Statement of Intent

Purpose of Shadow Request: Senior Project: ☐ Pre-requisite for admission into a clinical education program: ☐

Class Assignment: ☐ Job Applicant: ☐ Exploring career options: ☐

Specify the days of the week, best for your schedule: Mon: ☐ Tues: ☐ Wed: ☐ Thurs: ☐ Fri: ☐ Sat: ☐ Sun: ☐

Preferred times: Morning: ☐ Afternoon: ☐ Evenings: ☐ **Specify date, best for your Schedule:** _____ (mm/dd/yyyy)

Discipline or role you wish to shadow *(nursing, nursing support, allied health)*: _____

Department: _____ Mentor Name (if known): _____

Desired goals or outcome of your shadowing observation at a ECU Health facility: _____

Conduct Expectations *(initial each section to confirm you have read and agree)*

_____Dress Code Requirements

I understand that appropriate attire for the shadow experience includes at a minimum; slacks, skirts, blouses, dresses and shirts with collars. Preferred attire is slacks or khaki style pants with a collared shirt. Wear clean closed toe and heel shoes, no open toe or open heel shoes will be allowed. Clothing should not be excessively tight or excessively baggy. Ripped, torn and dirty clothing is not appropriate. **No scrubs.** (NOTE – some units may issue sterile scrubs to be worn once on-site). If I am deemed to be dressed inappropriately, I understand that I will be asked to leave the premises.

_____Promptness and Reliability

I understand that it is important to arrive at the agreed upon time. Staff is anticipating my arrival, and I am expected to allow myself plenty of time for parking, walking time, and location of the unit. If I am going to be late or unable to come on the designated date, I need to contact the mentor, their office or department, or the Educator to whom I submitted my original application to inform them of that situation.

_____Professionalism

I understand that I must behave in a courteous manner at all times. **Cell phone usage is not allowed** during shadowing. I will turn the device off while on campus. If at any time my behavior is considered inappropriate or not in compliance with ECU Health rules and regulations, I will be asked to leave. I understand that ECU Health expects that I exhibit a positive and engaged attitude.

_____Infection Control

I agree that I do not, to the best of my knowledge, have an infectious disease or a contagious health problem that might or could risk a patient's or team member's health at a ECU Health entity. I agree to immediately notify the entity and do so before coming on site if I contract or become aware that I have a health problem that might put at risk the health of a ECU Health patient or team member. I agree to follow all Personal Protective Equipment/Safety guidelines (masking, screening, safe distancing) while on ECU Health premises.

_____Confidentiality

I agree to not repeat or otherwise share confidential patient information as required by related state and federal laws. I understand that this includes patient names, health related information or any patient-specific information I come in contact with during my shadowing experience. I will only make known this information as allowed by law after contacting my Shadowing Supervisor.

_____Criminal Background *(Check appropriate box)*

☐ I have never been found guilty or plead nolo contendre to any felony and/or misdemeanor, or to any other offense (excluding minor traffic offenses), involving violence, injury to person, destruction of property, sexual offenses, drugs, theft or moral turpitude. I do not have any pending criminal charges against me. This includes any felony offense or any offense involving violence, injury to person, destruction of property, sexual offenses, drugs, theft or moral turpitude. I understand and agree that I am under a continuing obligation to advise my Shadowing Supervisor of any changes in my criminal record throughout the entirety of my observation experience.

☐ I have pending charges or have been found guilty or plead guilty or nolo contendre to a felony and/or a misdemeanor offense (excluding minor traffic offenses), and have listed on a separate sheet of paper every conviction or charge pending and the county and state where I was convicted or where pending (If convicted, please include the year of the conviction. In lieu of attaching a separate sheet of paper you may attach a copy of your criminal record). I understand that my application, along with my list of convictions and/or pending charges, may be referred to a hospital committee for further review before I am permitted to participate in the shadowing experience. I understand and agree that I am under a continuing obligation to advise my Shadowing Supervisor of any changes in my criminal record throughout the entirety of my observation experience.

Read and Agree to Shadow Policy and Conduct Expectations

I have read both the Shadow Policy and Conduct Expectations. I am aware a shadow experience is an **OBSERVATION-ONLY** experience and I am not allowed to engage in patient care in any way as a shadow. I agree to abide by all the rules and regulations of the ECU Health entity or entities that host my shadow experience, as well as each entity's policies and this Conduct Expectations. I am aware that if I violate any ECU Health rules or regulations my shadow experience may be terminated immediately. Additionally, if I do not meet the Dress Code on day(s) in which I am scheduled to shadow, I will not be allowed to complete the shadow experience on that day. I understand that a department may make special accommodations for my shadowing; therefore, if something happens and I am not available during the time that I have been scheduled for, then I MUST notify the department. Rescheduling arrangements may be discussed at that time or later. In addition to any reasons discussed in this Agreement, I understand that my shadow experience may be terminated for any misinformation or omission of fact appearing on this application form, checklists, for any violation of ECU Health rules or regulations, or for violation of this Conduct Expectations.

SHADOW PARTICIPANTS MUST COMPLETE and SIGN BELOW:

_____ _____ _____

Printed Name of Shadowing Participant (Required) Signature of Shadowing Participant (Required) Date

_____ _____ (____)_____

Printed Name of Witness (Required) Address of Witness (Required) Witness Phone (Required)

_____ _____

Witness Signature (Required) Date

IF SHADOW PARTICIPANT IS UNDER 18 YEARS OF AGE, PARENT/GUARDIAN MUST ALSO COMPLETE and SIGN BELOW:

_____ _____ _____

Printed Name of Parent/Guardian (Required) Signature of Parent/Guardian (Required) Date

_____ _____ (____)_____

Printed Name of Witness (Required) Address of Witness (Required) Witness Phone (Required)

_____ _____

Witness Signature (Required) Date

Release and Waiver from Liability

I voluntarily release ECU Health, its successors, assigns, affiliates, subsidiaries, directors, officers, agents, and team members ("ECU Health") from all liability for any claim or cause of action, I, my heirs, or assigns, might now or hereafter have for injury, loss, damage, or death arising out of, or incident to, my shadow experience. I agree to hold ECU Health harmless from all claims, losses, liability, and demands that may be realized due to my negligence, gross negligence, willful misconduct, or violation of this Agreement. I understand that the privilege of being allowed to observe depends on my executing and complying with the Agreement. I understand that this privilege may be revoked or modified at any time without cause or prior notice at the entity's sole discretion. I have read and understand this Agreement as well as the Release and Waiver from Liability.
No Shadow Participant will be allowed in a suspected or confirmed COVID positive patient room/unit.

SHADOW PARTICIPANTS MUST COMPLETE and SIGN BELOW:

I hereby consent to follow all of the rules set forth in this Agreement. I realize I must act responsibly and professionally 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.

_____ _____ _____
Printed Name of Shadowing Participant (Required) Signature of Shadowing Participant (Required) Date

_____ _____ (____)_____
Printed Name of Witness (Required) Address of Witness (Required) Witness Phone (Required)

_____ _____
Witness Signature (Required) Date

IF SHADOW PARTICIPANT IS UNDER 18 YEARS OF AGE, PARENT/GUARDIAN MUST ALSO COMPLETE and SIGN BELOW:

I, the undersigned, herewith consent that my daughter/son may observe with ECU Health for a shadowing experience, and I expressly release that entity from any and all claims which arise out of the observation experience as noted above.

_____ _____ _____
Printed Name of Parent/Guardian (Required) Signature of Parent/Guardian (Required) Date

_____ _____ (____)_____
Printed Name of Witness (Required) Address of Witness (Required) Witness Phone (Required)

_____ _____
Witness Signature (Required) Date

ECU Health – OFFICE USE ONLY

Date Participant Cleared: _____ Cleared by: _____

ECU Health Entity providing Shadow Observation: _____

Unit(s) / Department(s) observed: _____

Shadow Dates: _____ Approved Shadow hours: _____