Dear Applicant,

The goal of this program is to enable participants to learn about health careers while shadowing/observing Carilion employees. Participants may not take part in hands-on patient care and may not shadow without doing as described below.

Eligibility
• Applicants must be 16 and older.
• Placement is not guaranteed and depends on staff availability.
• We schedule a maximum of three 4- or 8-hour visits during a twelve month period. When we schedule visits on days the application lists as available but the applicant is unable to attend, we do not reschedule.
• Due to concern for patient confidentiality and visitor safety, some departments do not provide shadow experiences. On some occasions, shadowing opportunities may be suspended for students 18 and younger.
• TB screenings: If you will shadow in a patient area, you must complete and return the attached TB Screening Form with your paperwork.

Dates and Deadlines
• Complete the TB Screening Form first. Then complete the other forms.
• Pages 2-6 must be received at Visiting Student Affairs by the following applicable deadline.

<table>
<thead>
<tr>
<th>If This Is Your Situation</th>
<th>Do This on the Application</th>
<th>Send Us the Paperwork At Least</th>
</tr>
</thead>
<tbody>
<tr>
<td>You want to shadow a specific Carilion employee,</td>
<td>include that person’s name on the application under “Requested Profession.”</td>
<td>3 weeks in advance</td>
</tr>
<tr>
<td>A Carilion employee agreed to let you shadow,</td>
<td>list the employee’s name and dates or date range on the application under “Pre-Arranged.”</td>
<td>1 week in advance</td>
</tr>
<tr>
<td>Neither of the above is true,</td>
<td>complete all sections of the application except “Pre-Arranged.”</td>
<td>3 weeks in advance</td>
</tr>
</tbody>
</table>

Appropriate Dress
• Business casual attire is required. That means that you, your hair, and your clothes must be clean and neat, and that you may not wear jeans, shorts, leggings, sweats, Capri pants or t-shirts. You may not wear white lab coats, personal scrubs, perfumes, or heavy jewelry. If you shadow in a clinical area, you must wear comfortable closed-toe shoes. Questions about appropriate attire can be directed to Visiting Student Affairs at visitingstudentaffairs@carilionclinic.org.
• All observers must wear the Carilion ID Badge issued by Visiting Student Affairs.

We look forward to helping you explore your career options in healthcare and hope this experience will be rewarding.

Sincerely,

Visiting Student Affairs
Fax: (540) 983-1189
E-mail: visitingstudentaffairs@carilionclinic.org
Mailing Address: Visiting Student Affairs, CRMH, P.O. Box 13367, Roanoke, VA 24033-3367
Carilion Employees or Volunteers, the form is complete once you list your name and badge number in the chart. Return this form WITH your other paperwork.

All Other Applicants, you must show negative results on one of the TB screening tests in the list below.
- Two-step PPD skin test are required for first-time tests and repeat skin tests more than 3 months out-of-date.
- QuantiFERON-TB Gold test
- Chest x-ray

1. Complete this chart.

   I, the Applicant, authorize the administering provider to share TB screening results with Carilion Clinic Visiting Student Affairs.

<table>
<thead>
<tr>
<th>Printed Name of Student Observer</th>
<th>Date (MM/DD/YY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student Signature</td>
<td></td>
</tr>
<tr>
<td>Printed Name of Parent (if minor)</td>
<td></td>
</tr>
<tr>
<td>Signature of Parent (if minor)</td>
<td>Date (MM/DD/YY)</td>
</tr>
</tbody>
</table>

2. TAKE THIS FORM to a health care provider or school official to complete the bottom of the form.
3. Once this form is completed, follow the directions on the remaining forms.
4. Return this form WITH your other paperwork. NO OTHER FORMS ARE ACCEPTED.

Health Care Provider or School Official, initial tests and skin tests more than 3 months out-of-date MUST BE THE TWO-STEP TEST. These blanks and the chart must be completed AFTER screening results are known. RETURN THIS FORM TO THE APPLICANT.

   ___ Two-step PPD skin test
   ___ QuantiFERON-TB Gold test
   ___ Chest x-ray

   I certify that the individual above had negative results on the TB screening checked above on (MM/DD/YY) ________________ and is approved to observe professionals in a healthcare setting.

<table>
<thead>
<tr>
<th>Signature of Official Completing This Form</th>
<th>Date (MM/DD/YY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Printed Name</td>
<td>Title</td>
</tr>
<tr>
<td>Name of Practice or School</td>
<td>Address</td>
</tr>
<tr>
<td>Title</td>
<td>Phone</td>
</tr>
</tbody>
</table>
Application for Observation

Save to a PC. Click your cursor in the first blank and type. Then tab and type to the end. Complete by hand as a last resort.

Legal Name

M F

Last Name, First Name and Middle Initial

Age

Date of Birth

MM/YY

Cell Phone

Last Flu Shot

Address

Preferred Email Address

Home Phone

Last Name, City, State, Zip Code

Current or Most Recently Attended School or Program

Highest Level of School or Training

Major or Program

Emergency Contact Name

Relationship

Phone Number(s)

Emergency Contact Name

Relationship

Phone Number

Objectives for Observation

1.

2.

Requested PROFESSION (RN, NP, PA, etc.) and DEPARTMENT (ED, Ortho, Peds, etc.)

1st Preference: Profession

Department

Max. No. of Days

2nd Preference: Profession

Department

Max. No. of Days

Requested FACILITY (Use numbers to list choices in order of preference.)

__ Carilion Medical Center (Roanoke facilities)

__ Carilion Franklin Memorial Hospital

__ Carilion New River Valley Medical Center

__ Carilion Giles Community Hospital

__ Carilion Stonewall Jackson Hospital

__ Carilion Tazewell Community Hospital

__ Other:

Requested DATES & TIMES (If a Carilion employee has NOT already agreed to let you shadow, complete this section after the TB Screening Form has been completed.)

Check the deadlines in the cover letter, list below several dates or date ranges you’re available and the earliest time of day you can be at the above facility and the latest time you must leave. block these dates on your calendar until we email you the results. Check email frequently, including Spam and Junk folders.

For Pre-Arranged Shadow Visits (If a Carilion employee has agreed to let you shadow, complete this section.) The earliest date must be at least 1 week after all completed paperwork, including our TB Screening Form, is received at VSA.

Employee’s Name

Unit/Department

Phone

E-mail address

Employee’s Signature

Date

Dates and Times Agreed on (Must include a start and end date)

Leave this section to bottom of the page blank.

Approved Date and Time

Approved Unit/Department

Unit/Department Manager Approval
Access & Confidentiality Agreement

I am a member of one of the following groups which has access to Confidential Information of Carilion Clinic and/or its affiliated companies (“Carilion”) and need to be aware of and abide by the laws and policies that apply to confidential information:

- Carilion employees;
- Business Associates;
- Physicians or employees of physicians;
- Sales Representatives;
- Committee Members;
- Board Members;
- Students / Residents
- Volunteers; and
- Contracted employees and their employees

Confidential information is protected both by law and strict Carilion policies. The intent of these laws and policies is to assure that confidential information is accessed and shared only to the extent necessary and appropriate in the performance of job-related duties.

Confidential information is defined as anything that is expected to remain private by us or those individuals with whom we interact and includes information relating to:

a. patients and plan members (such as medical records, photographs, video images, conversations, admitting information, diagnosis, test results, patient financial information, etc.);

b. employees (such as salaries, employment records, disciplinary actions, etc.);

c. Carilion (such as financial and statistical records, strategic plans, internal reports, peer review information, business practices, software and documentation developed by individuals for Carilion, etc.);

d. third parties (such as provider and payor contracts, client and vendor agreement information, software and documentation developed for or used by Carilion, etc.); and

e. providers (such as medical records, credentialing information, malpractice or disciplinary actions, financial or business records).

Confidential information may be used only as needed to perform my specific job or activity related responsibilities. Access to confidential information is subject to periodic review, revision, and, if appropriate, renewal.

As an employee, affiliate or other group member of Carilion, I am required to comply with the laws and Carilion policies and guidelines relating to confidential information. I understand that:

1. I may have access to confidential information and I am responsible for protecting all confidential information.

2. Confidential information may only be used as needed to perform my specific job responsibilities or assigned activities. I may:
   a) only access confidential information for which I have a need to know;
   b) not disclose, copy, release, sell, loan, review, alter or destroy any confidential information except in the scope of my regular job responsibilities or assigned activities;
   c) not share or disclose specific patient health information or specific provider information with anyone other than those persons within or outside the organization authorized to see such information;
   d) not misuse or be careless with confidential information;
   e) not take photographs or video taped views of patients or patient family members unless it is directly related to my job; and
   f) only access the minimum necessary clinical or demographic protected health information (PHI) to perform my job responsibilities or other assigned activities.

3. Carilion may revoke my access codes, other authorization or access to confidential information at any time.

4. I must safeguard and not disclose or share my access codes, passwords, or any other authorization I have that allows me to access confidential information. I understand that I am responsible for all activities undertaken using my access codes, passwords, or other authorizations.

5. I will report to the Privacy Officer, (540) 981-7751, or my site risk manager, activities or individuals that I suspect may compromise the confidentiality of information.

6. I have no right or ownership interest in any confidential information referred to in this Agreement.

7. My obligations under this Agreement will continue after separation from employment with Carilion.

8. Violating this Agreement or Carilion’s confidentiality policy and guidelines will subject me to corrective action, which may include:
   a) loss of access to information;
   b) loss of privileges at Carilion;
   c) separation of my employment;
   d) legal liability; and
   e) civil or criminal penalties or monetary fines

I understand that I am not allowed to use my Carilion authorized access to health information or demographics including addresses or birthdays, about my co-workers, other employees, friends, neighbors, or family members unless the information is needed to perform my job responsibilities. Specifically, as it relates to getting personal information about my family members or others, I understand that I am required to use the same process used by non-employees which is to go to Health Information Management (Medical Records) and sign an authorization form. Should I have access to my own health information (electronic or hard copy) in accordance with Carilion policy, I am not allowed to modify my own medical record nor create, authorize or sign my own prescriptions. If I have a specific need for health information, I will work with my manager and the Corporate Privacy and Information Security Officer for access.

By signing below, I acknowledge that I have read and understand the above Agreement and agree to abide by the terms of this Agreement and the confidentiality policy and guidelines as established by Carilion Clinic.

Print Name ____________________________ Date ____________________

Signature ____________________________ Last 4 digits of Your SSN or Employee Badge Number

Parent Signature (For minors) ____________________________
Observer Program Participation Agreement

I am participating in various practical, clinical, and/or observational experiences (Educational Experiences) either (i) through a school which has entered into a Student Program Agreement to do observation or clinical participation with the Provider, or (ii) through an independent Educational Experience approved and accepted by the Provider pursuant to this Agreement.

Policies and Procedures: In consideration of my acceptance into said Educational Experience, I understand and agree that while participating in the Educational Experience, I am subject to all of the Provider’s rules, policies and procedures, including those relating to appearance and behavior. I further understand and agree that I may be required to withdraw from the Educational Experience if my performance is unsatisfactory; or if I fail to comply with said rules, policies, and procedures; or if my health status, taking into account all reasonable accommodations, is a detriment to my successful completion of the Educational Experience.

Confidentiality: I understand and agree that the services the Provider performs for its patients and the information patients furnish to it are highly confidential. It is the Provider’s obligation and policy to protect the patient’s right to privacy and to maintain the confidentiality of all patient medical records, including the identity of patients, the services performed for them, and all information concerning their affairs (hereafter referred to as the “Patient Information”). Provider’s good will depends upon, keeping such patient information confidential.

In addition to Patient Information, I acknowledge that the Provider’s operation, policies, procedures and records constitute important business assets and are confidential. Such records include, but are not limited to personal records, strategic plans, policy and procedure manuals, bookkeeping and other accounting information, and all such documents and records related to Provider’s business activity (hereinafter referred to as “Business Information”).

By reason of my participation in the Educational Experience, I may come into possession of Patient Information or Business Information. I understand and agree that the Patient Information and Business Information obtained by me during my participation in the Educational Experience shall not be revealed to anyone without the signed written authorization from the patient or guardian in the case of Patient Information or from the Provider in the case of Business Information. I agree not to permit anyone to examine or make copies of any Patient Information or Business Information that may come into my possession.

Assumption of Risks: As a participant in the Educational Experience, I may be allowed to observe or, where applicable to the Educational Experience, participate in clinical activities in patient care areas, including high risk patient care areas such as the Emergency Department or Adult Special Care Units. I understand that in such high-risk patient care areas that Provider’s policies may restrict my activities and observation may be limited to certain specified areas.

I understand that there are risks and hazards associated with participating in the Educational Experience in a health care setting, particularly in circumstances where I am permitted in high-risk patient care areas. Further, I understand that in spite of appropriate precautions, there are risks of infections and contradicting communicable diseases. Also if I do not use proper care and follow directions given to me, I may injure others or myself or cause damage to my property or the property of others. By participating in the Educational Experience, I agree to assume such risks, including the added risks associated with high-risk patient care areas. I agree to accept responsibility for my own actions and not to hold Provider responsible for such actions. I will not seek damages or other compensation from Provider for any injuries to me or my property, unless such injuries are caused by the gross negligence or willful misconduct of the Provider, its employees or agents, nor will I ask the Provider to pay for any injuries that I might cause to others or the property of others, including Provider’s property, except to the extent that such injuries are not covered by my insurance, but are covered by the Provider’s insurance.

Binding Agreement: I acknowledge that I have read this Agreement and that I understand and agree that any violation of this agreement may involve violations of state and federal laws and regulations governing the patient’s right to privacy or the right of a company to maintain the confidentiality of its business records. I recognize that the disclosure of information by me may give rise to irreparable injury to you or your patients and that you or your patients may seek any legal remedies against me that may be available in the event of such disclosure.

Applicant’s Signature Date (MM/DD/YY)

Applicants under 18 years of age must have parental or guardian consent

As parent or guardian of the student applicant under eighteen (18) years of age, I acknowledge and accept the terms set forth above.

Parent or Guardian Signature Date (MM/DD/YY) Minor’s Printed Name
Observer Guidelines

Appearance and Grooming
Your appearance is important because it helps maintain our professional image. You and your clothing should be clean and neat. Business casual with comfortable closed-toe shoes are appropriate, but jeans, shorts, skirts, t-shirts, perfume, and heavy jewelry are not. Using good judgment in style of dress and appearance is essential. Questions concerning appropriate dress can be directed to Visiting Student Affairs.

Identification Badge
Visiting Student Affairs will issue a temporary ID badge as a means of identification. Badges should be worn on an outer garment, waist level or higher. The ID badge must be returned at the end of your visit.

Confidentiality
Carilion must assure that the operations, activities, and business affairs of the hospital, patients, and customers are kept confidential. During the healthcare experience, students may receive confidential or business related information about the hospital, customers, or co-workers. This information must be handled in strict confidence and should not be discussed outside the hospital. Our patients have the right to expect that personal details will not be discussed in or out of the hospital, except in conversations on the unit where they directly related to care. Direct questions about a patient to the nurse in charge or the nurse manager. Written consent is obtained from the patient before information is released.

Drug Free and Smoke Free Workplace
Carilion makes every effort to maintain a drug-free and smoke-free workplace. The abuse of controlled substances subjects all employees, visitors, and patients to safety risks and affects our ability to operate effectively and efficiently. The unlawful possession, distribution, dispensing, sale, or use of a controlled substance in the workplace or while engaged in company business on or off Carilion premises is strictly prohibited. Most Carilion facilities have designated smoking areas off-site but nearby. Smoking in any smoke-free area subjects the offender to immediate dismissal.

Parking
Directions for parking at Carilion Clinic facilities will be forwarded along with your shadow confirmation email.

Safety
Carilion provides a safe and healthy place to work. Precautions are taken to protect against occupational hazards or accidents. In some cases, policies will be department-specific. This will be discussed in orientation at safety meetings and during specific periodic in services or reviews. Each student must follow all hospital safety policies. Job safety is everyone’s responsibility. Report any unsafe conditions to the nurse manager or charge nurse.

Food Services
Food service in the hospitals is available for hot meals in the hospital cafeteria. Students may also use the cafeterias when bringing meals from home. Vending machines are available 24 hours a day.

Schedule Changes or Cancellations
To ensure the safety of our patients and staff, you may not attend your scheduled shadowing visit if you experience any of the following symptoms in the 48 hours prior to your visit—fever, cough, diarrhea, chills, chest pain, shortness of breath or vomiting. Immediately contact Visiting Student Affairs so they can let the department know you will not be coming. You may be rescheduled for another date after being symptom free for at least 24 hours.

Students who will be late or cannot observe due to a family/personal emergency must contact Visiting Student Affairs. Any changes in the schedule must be approved by the department.

Signature                  Date (MM/DD/YY)                      Print Your Full Name
Procedure for Evaluation and Follow-up for Exposure Incidents for Students Using Carilion Health System Facilities for Clinical Experiences

An exposure results when

- you are injured with contaminated instruments (contaminated needles, blades or sharp instruments)
- your mucous membranes (mouth, eye) or a wound come in contact with someone else’s blood or body fluids
- your skin has either prolonged contact with someone else’s blood or contact with large amounts of blood, especially when the exposed skin is chapped, abraded, or afflicted with dermatitis

Should an exposure occur, immediately notify your supervisor, cleanse the exposed area, and report to Employee Health (M-F 8:00am to 4:00pm). If the exposure occurs at any other time, ask your supervisor to page the Clinical Administrator. That person will meet you where you are and take you to the Emergency Department, if necessary.

Within 24 hours of the exposure, you must complete a Student Event Report so that initial evaluation of the blood exposure and the first dose of prophylaxis, if recommended, can be covered by Employee Health Services.

If necessary, blood testing will be drawn on the source patient in accordance with Virginia Code 322.145.1. The hospital will assume the cost for source patient blood testing.

Workman compensation does not cover students. The student will be responsible for all other costs associated with the follow-up. They have the choice to go to their own private physician or to pay the Occupational Health/Emergency/Employee Health Department charge. If the student chooses to go to their private physician, source patient blood testing will not occur unless they inform the Occupational Health/Emergency/Employee Health Department of the exposure immediately.