UnityPoint Health
Grinnell

Career Shadow Application

CONTACT INFORMATION

Full Name (First, Middle Initial, Last): _____
Home Address: _____
City, State, Zip: _____
Phone: _____
Email: _____
Date of Birth: _____

Name of School Currently Attending: _____
Year in School: _____
Program of Study: _____
Are you receiving classroom credit for this job shadow? ☐ Yes ☐ No
Is the observation experience a required prerequisite for a course or program? ☐ Yes ☐ No

Please provide any special accommodation needs:

OBSERVATION INTEREST

Select Observation Request. Select one.
☐ Virtual Interview ☐ In-person Interview ☐ In-person Observation
**If under the age of 18 years old, signed parental consent is required.*

Department/Occupation Interest. Please list which department/occupation you are interested in observing/interviewing.

Identify dates and times you are available for your interview or observation request:

PARENTAL CONSENT (required if under age 18)

Please provide name and contact information for parent/legal guardian:
Contact Name: _____
Relationship: _____
Phone: _____

To be completed by parent/legal guardian:
☐ I _____ (parent/legal guardian name), approve _____(learner's name) to participate in UnityPoint Health's Career Shadow Program.

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COMPLETE THE FOLLOWING SECTION FOR ALL IN-PERSON INTERVIEW OR OBSERVATION REQUESTS

Emergency Contact Name #1: _____
Relationship: _____
Phone: _____

Emergency Contact Name #2: _____
Relationship: _____
Phone: _____

Primary Care Physician: _____
Phone: _____

IMMUNIZATION INFORMATION: REQUIREMENT FOR IN-PERSON OBSERVATION ONLY

Immunization and proof of COVID vaccination information must be received before acceptance into an in-person observation experience. (Virtual and in-person interviews do not require immunization information.)

Provide *acceptable** medical evidence that you have received the below immunizations to participate in an in-person observation. UnityPoint Health – Grinnell will not provide any of these immunizations; they are at the expense of the learner.

1. Submit a copy of your immunizations as part of your application. If this is not received as part of your application, you will not be able to participate, and your application may be closed without notification.
2. Immunizations required:
    a. **Measles, Mumps, Rubella (MMR):** Two valid doses of MMR vaccine or laboratory results indicating evidence of immunity to Measles, Mumps, and Rubella.
    b. **Influenza Vaccination:** If your observation experience is between October-March.
    c. **COVID Vaccination:** Fully vaccinated against COVID-19 (two doses of Pfizer or Moderna, one dose of Johnson & Johnson) OR an approved exemption to begin shadowing at UnityPoint Health. COVID booster strongly encouraged.

*Acceptable documentation may include: physician records, military records, employer records, school records, IRIS immunization record, hospital record, and immigration documentation. Hand-written records need to be on official letterhead with an official signature. Baby book records are not acceptable.

Do you have any allergies? _____
Do you have an allergy or sensitivity to latex? _____

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ATTESTATION

The information provided on this application is true and complete to the best of my knowledge. I verify I have received, read, and understand the UnityPoint Health – Grinnell Self-Guided Orientation outlining the following UnityPoint Health – Grinnell policies and procedures:

a. Confidentiality and HIPAA
b. Infection Prevention
c. Personal Protective Equipment
d. Safety
e. Professional Conduct
f. Professional Appearance

To be completed by the learner:

☐ I _____ (learner's name), verify I have completed the self-guided orientation as stated above.

CONSENT AND RELEASE FORM

In consideration of the opportunity to voluntarily participate in a learning program at UnityPoint Health – Grinnell as part of the Career Shadow Program, I agree to the following:

1. I certify that I am at least fourteen (14) years of age or older.
2. I understand that patients undergoing examination, procedure, or treatment must consent to my presence.
3. I agree to maintain and protect the absolute confidentiality of the names of the patients and any other patient identifying information, as well as all information relating to the condition, diagnosis, treatment of any patient of which they become aware during the course of observation.
4. I understand that this is an observation only experience. I agree not to provide care of any kind to any patient or to write on any patient's medical record.
5. I understand that UnityPoint Health – Grinnell will not assume nor provide any type of insurance coverage, including malpractice insurance coverage, for me while I am on hospital premises.
6. I will wear an identification badge at all times while in the organization identifying me as a voluntary observer. I will conduct myself in a professional manner and surrender the badge to the designated office/person when the experience is completed.
7. I understand that I will, at all times, remain in the presence of the individual whom I am interviewing or observing. I will leave the patient care areas when the interview or observation is complete and the hosting individual(s) leave.
8. I acknowledge that no assurance or representation concerning my health or safety during the period of my voluntary interview or observation experience have been made to me. I understand that numerous risks to health and safety may be present in a hospital, including but not limited to personal injury or exposure to infectious agents, and I voluntarily assume all risks associated with my presence in the organization as an observer.

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9. I understand that UnityPoint Health – Grinnell requires that its employees, invited guests and observers have the appropriate immunizations. I further understand that my failure to obtain and/or show proof of these immunizations prior to an in-person observation experience will result in its termination.
10. I understand that UnityPoint Health – Grinnell reserves the right to terminate the voluntary interview or observation experience at any time.
11. I certify that I have never been convicted of a crime.

I hereby release UnityPoint Health – Grinnell, its parent, affiliates, and subsidiaries, its medical staff, physicians, directors, officers, employees, agents, and representatives from any liability, injury, or damages caused by or arising from or in connection with my presence as an observer or learner in the organization.

By voluntarily signing below, I acknowledge that I have read this Agreement and will comply with all terms and conditions stated.

_____
Observer's Name (please print)

_____ _____
Signature of Observer Date of Signature

_____ _____
Signature of Parent/Legal Guardian if under 18 years old Date of Signature

Save a completed copy of this document and email it to the program for which you are interested in participating. Email information can be found on the website.

Submit Form Clear Form