



Dear Student / Shadow,

Please fill out the attached application. In order to shadow at PAMC, You must be at least **16 years of age** and be in an education program or be able to verify/provide a letter that you intend to enter the medical field. It is your responsibility to find a provider willing to have you shadow them. If you do not know of one, here is a link to our provider page to search for a provider by specialty or name.

<http://providencealaska.netreturns.biz/Providers/Default.aspx>

You must have the provider you are shadowing sign page 5 and 6 of the application – without signatures; we cannot accept your application. When you have a complete application along with the supporting documentation, please forward your completed application to our office for review. You will then be contacted to schedule an appointment for orientation and badging.

At your appointment, please remember to ***bring a government issued photo id (driver's license or passport)***. We will do a brief orientation and issue you a badge - this only takes about 20 minutes. If you are under the age of 18, your parent or guardian will have to sign the paperwork in the appropriate places.

Medical Staff Services
Providence Alaska Medical Center
3200 Providence Dr. Suite B02
Anchorage, AK 99508
Phone 907-212-3185
Fax 907-212-4865
Email medicalstaffoffice-pamc@providence.org

3200 Providence Drive Suite B02, Anchorage, Alaska 99508
 (907) 212-3185 Phone, (907) 212-4865 Fax, medicalstaffoffice-pamc@providence.org Email

INSTRUCTIONS: Students and Professionals seeking to participate in the shadowing of a provider at Providence Alaska Medical Center must fill out this application and the other forms listed.

These forms MUST be completed and received prior to the shadowing experience.

Clearly state Not Applicable or N/A if section or question is not relevant to you.
 Ensure that required documentation is attached (as listed below) and return to:

Providence Alaska Medical Center
 Medical Staff Services Department
 3200 Providence Drive Suite B02
 Anchorage, AK 99508

Please ensure the following are included and have been completed:

- Completed application
- Immunization Attestation form
- Consent and Release form
- Confidentiality Statement form
- The Supervising Provider form and Job Shadow Guidelines
- Written Statement form

Additional Professional Reference Letter Required:

- Professional Reference (this reference must include an explanation to the purpose and reason for such a shadowing experience).

SECTION A			
Personal Information			
Last Name	First Name	Middle Name or Middle Initial	Degree (if applicable)
Date of Application	Specialty/Area During Shadowing Experience		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Dates of Shadow From: _____ To: _____	Name of Supervising Provider		
Email Address		Contact#	
Home Street Address		Home City/State/Zip	
Date of Birth	Age	Birth City/State	Birth Country
Other Names by which you have been known			

SECTION B		
Education and Training		
Education: High School, Undergraduate, etc.		
Name of Most Current Educational Institution Attended	Start Date	Graduation Date
City/State	Phone Number	Degree Obtained

Employment		
Indicate Name and Position with Current Employer:		
Name of Company/Business	Position/Job Title	Start Date
City/State	Phone Number	Supervisor's Name

SECTION C

Professional References: <i>Include the name and a letter of reference from an individual who can attest to your professional reasons for this shadow experience. This person must have recent (within the past two years) exposure to your professional schooling.</i>	
Name of Reference	
Reference's affiliation to you?	
Phone Number	E-Mail Address

SECTION D

Disclosure Questions		
<i>If you answer "YES" to any questions number 1 through 7, please provide details on a separate page. Include a copy of any order or settlement where applicable.</i>		
1.	Have you ever been the subject of an informal or formal hearing process at any hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Has any professional body, either state or federal ever sanctioned you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Have you ever been convicted of, or pleaded guilty or nolo contendere to any crime other than a minor traffic violation, or are charges pending against you for any such crimes by information, indictment or otherwise?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	During the last ten years, have you been under the influence of alcohol during working hours or have you used illegal drugs? If "YES", please provide details.	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Have you ever been court-martialed, investigated, sanctioned, reprimanded or cautioned by a hospital or other healthcare facility of any military agency, been involuntarily terminated or forced to resign, or have you resigned voluntarily while under investigation or threat of sanction from a hospital or healthcare facility of any military agency?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Have you ever been diagnosed with, treated for, or are you currently afflicted by voyeurism, pedophilia, exhibitionism, or any other sexual behavior disorder? ("Sexual behavior disorder" does not include or imply sexual preference.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Are you currently using any chemical substance(s), legal or illegal, that in any way impairs or limits your ability to practice medicine in a safe and competent manner?	<input type="checkbox"/> Yes <input type="checkbox"/> No

The information given in or attached to this application is accurate and complete to the best of my knowledge, information and belief. By placing my signature below, I understand that this shadowing experience at Providence Alaska Medical Center is intended to be strictly observational. I understand that I am not permitted to touch patients/residents of any Providence Health & Services entity, handle patient resident care equipment and/or supplies as it relates to their care (this includes passing instruments). I understand that I am not permitted to discuss patient/resident conditions with patients/residents and/or their family members, nor am I to discuss what I have heard/seen and/or learned during my shadow experience with anyone outside of those appropriate persons in the Providence Health & Services system. I understand that my doing so, may constitute a HIPAA privacy violation.

Signature of Shadow: _____ Date: _____

If Shadow is a minor (under 18 years of age):

I as parent or guardian of the above named minor do hereby consent to this minor's participation in the shadow experience at Providence Alaska Medical Center. I agree to the provisions as listed above and adopt it as my own and agree to reimburse PAMC for any damage incurred by it for which this minor would be liable were he/she 18 years of age.

Signature of Parent or Guardian: _____ Date: _____

Printed name of Parent or Guardian: _____

SECTION E: IMMUNIZATION ATTESTATION FORM

Influenza Vaccinations

Influenza Vaccination	Date:
Did you receive your influenza vaccine at PAMC?	<input type="checkbox"/> Yes <input type="checkbox"/> No

OR

Declination due to medical indications	Date:
Declination due to other reasons	Date:

Hepatitis B Vaccinations

Hepatitis B Vaccination (1 st , 2 nd , & 3 rd)	Date:	Date:	Date:
Did you receive your Hepatitis B vaccine at PAMC?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

OR

Hepatitis B Titer Showing Immunity	Date:
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MMR Vaccinations

MMR (Measles, Mumps, Rubella) Vaccination (1 st & 2 nd)	Date:	Date:
Did you receive your MMR vaccine at PAMC?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

OR

MMR Titer Showing Immunity	Date:
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Varicella Vaccinations

Chicken Pox (Varicella) Vaccination (1 st & 2 nd)	Date:	Date:
Did you receive your Varicella vaccine at PAMC?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

OR

Varicella Titer Showing Immunity	Date:
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TB Tests

2 Non-reactive TB tests (0 mm PPD) (1 st & 2 nd) within the past 12 months	Date:	Date:
OR		

Negative QuantiFERON-TB Gold Blood Test within the past 12 months	Date:
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OR

If positive TB test; medical clearance, including x-ray result	Date:
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Did you receive any of these tests at PAMC?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Printed name of School Nurse or Health Care Provider

Date

Signature of School Nurse or Health Care Provider

If you have printed copies of your immunization records from your health care provider's office that can be taken in replacement of the signatures.

SECTION F

Attestation and Consent & Release from Liability

PHS CENTRALIZED VERIFICATION SERVICE

I hereby apply to participate in a shadowing experience approved by the Medical Staff of Providence Alaska Medical Center. In return for my application being considered, I agree to be legally bound to the following terms and conditions:

1. To the fullest extent permitted by law, I extend immunity to, release from any and all liability, and agree not to sue any of the following entities or individuals if their actions are done in good faith:
 - (a) The Medical Center;
 - (b) Any authorized representatives of the Medical Center; and
 - (c) Any person providing information to or receiving information from the Medical Center, for any actions or communications relating to my application or any other professional review activity.
 - (d) The Board of Directors of Providence Health & Services acting as a review organization in the credentialing process.
2. In consideration of PAMC permitting me to participate in a voluntary learning experience, I agree:
3. I, for myself, my heirs, administrators, executors and assignees, hereby covenant and agree that I will never institute, prosecute, or in any way aid in the institution or prosecution of any demand, claim, or suit against PAMC and/or its agents or employees, acting officially or otherwise, for any loss, damage, or injury to my person or property which may occur from any cause whatsoever as a result of my participation in the activities at PAMC or going to or from the facility.
4. If I should demand, claim, sue, or aid in any way such a demand, claim, suit, I agree to indemnify PAMC all damages, expenses, and costs it may incur as a result thereof.
5. I authorize PAMC and authorized persons to share information with each other and consult with third parties regarding my competence, professional conduct, character, ethics, behavior, or other matters bearing on my qualifications.
6. The term "authorized representatives" means any persons who have any responsibility for obtaining or evaluating my credentials, acting upon my application or conducting professional review activity for any of the above referenced organizations, including governing body members, employees, medical staff or committee members, consultants and attorneys.
7. The term "professional review activity" means any action or communication by PAMC or any of the organizations or persons referenced above related to any:
 - (a) Determination as to whether I may be a shadow at PAMC;
8. I hereby certify that:
 - (a) I have never been convicted of any criminal felony or misdemeanor relating to the practice of my profession; any other health care related matters, third-party reimbursement, or controlled substance violations.
 - (b) I have never been diagnosed with, treated for, or are you currently inflicted by voyeurism, pedophilia, exhibitionism, or any other sexual behavior disorder?
 - (c) I am not using any illegal drugs or any other substance that would impair my ability to perform those essential functions.
9. I understand and agree that I may be held liable for any damages or loss to PAMC, which is caused, by my negligence, willful conduct, dishonesty or fraud.
10. Any misrepresentation, misstatement, or omission from this application, whether intentional or not, is cause for the immediate cessation of the processing of this application and no further processing shall occur, and my shadow experience will be denied. Upon subsequent discovery of such misrepresentation, misstatement, or omission, my shadow experience will be immediately ended.
11. I have read and fully understand the foregoing instrument and agree to the same by affixing my signature.

Signature of Shadow: _____

Date: _____

Printed Name: _____

If Shadow is a minor (under 18 years of age):

I as parent or guardian of the above named minor do hereby consent to this minor's participation in the shadow experience at Providence Alaska Medical Center. I agree to the provisions as listed above and adopt it as my own and agree to reimburse PAMC for any damage incurred by it for which this minor would be liable were he/she 18 years of age.

Signature of Parent or Guardian: _____

Date: _____

Printed name of Parent or Guardian: _____

SECTION G

Guidelines for Practicing Confidentiality

- Information about patients should not be discussed at breaks or meal times in a public setting.
- Patient information should not be discussed with health care workers not directly involved in their care.
- Medical and nursing records should not be left at any location where unauthorized personnel can see them.
- Patients must give permission for information (such as diagnosis) to be revealed to anyone. A patient may withdraw permission at any time. Such permission must be documented in the medical record of the patient.
- Patient information should not be discussed where it can be overheard by visitors and/or the public.
- When a patient is your neighbor or friend, you should be particularly careful not to reveal any information to mutual friends.
- No information about patients should be revealed to reporters, press, or media.
- Interviews with confused or disoriented patients are not permitted without family and/or provider's permission.

CONFIDENTIALITY AGREEMENT

I, _____, have read the guidelines above and agree to abide by them and do hereby agree to keep all information obtained regarding patients and/or provider's confidential. I hereby agree not to discuss any information obtained during the course of this job with persons outside the medical center. I release Providence Alaska Medical Center and its representatives of any liability arising from a breach of confidentiality caused by myself.

Signature: _____

Date: _____

Printed name: _____

If Shadow is a minor (under 18 years of age):

I as parent or guardian of the above named minor do hereby consent to this minors participation in the shadow experience at Providence Alaska Medical Center. I agree to the provisions as listed above and adopt it as my own and agree to reimburse PAMC for any damage incurred by it for which this minor would be liable were he/she 18 years of age.

Signature of Parent or Guardian: _____

Date: _____

Printed name of Parent or Guardian: _____

Supervising Provider:

I as the supervising provider of the above named individual and do hereby agree that I have read the guidelines above and agree to abide by them. I hereby agree not to discuss any information obtained during the course of this experience with the shadow, unless permission has been granted by the patient and documented in the medical record of the patient. I release Providence Alaska Medical Center and its representatives of any liability arising from a breach of confidentiality caused by myself.

Signature of Supervising Provider: _____

Date: _____

Printed name of Supervising Provider: _____

SECTION H

This form must be returned to the Medical Staff Office prior to your shadow experience.

Guidelines for Shadows and Supervising Provider Form

Name of Shadow	Name of Supervising Provider (<i>Must be a member of the ACTIVE Medical Staff at PAMC</i>)
Dates of Shadow experience (90 day period)	Supervising Provider's Department / Specialty

Guidelines for Student Shadows

- The Job Shadow must be referred by an appropriate source (i.e., active medical staff member, school counselor, teacher, program, etc.)
- The Job Shadow must meet with a staff member from the Medical Staff Services Department prior to their shadow experience to discuss the purpose of the experience. Individual will receive a brief orientation to PAMC, which will include general information, opportunities and expectations.
- Job Shadow is required to provide written statement releasing liability for Providence Alaska Medical Center. If under 18 years of age, a signed consent from parent/legal guardian prior to job shadow experience stating the release of liability for PAMC and permitting the learning experience.
- Job Shadow must review and sign confidentiality agreement, HIPAA (Health Insurance Portability and Accountability Act), and met immunization requirements prior to the job shadow experience.
- Job Shadow while participating in this job shadow experience is expected to:
 - Wear visitor identification badge at all times when shadowing in a visible location on your person.
 - Adhere to the Providence Code of Conduct Policy and maintain appropriate behavior while in the facility
 - Adhere to PAMC's mission and core values.
 - Respect patient's/resident's rights and privacy.
 - Dress in appropriate attire for PAMC (no jeans permitted)
 - Tattoos must be covered by clothing at all times.
 - Only pierced ears on the lower lobe of the ear are permitted on a person. All other piercing jewelry must be removed.
- The Job Shadow experience is intended to be strictly observational. Shadows are not permitted to touch patients/residents, handle patient/resident care equipment, supplies or to hand instruments under any circumstance. Shadows are not allowed to write in a patients chart or to discuss a patient as it related to their care. Nor may they discuss the patient/residents conditions with patients/residents family or anyone else in the room.
- Permission must be granted by the patient and/or the family/guardian of the patient for the shadow to observe.

The information given in or attached to this application is accurate and complete to the best of my knowledge, information and belief. By placing my signature below, I understand that this shadowing experience at Providence Alaska Medical Center is intended to be strictly observational. I understand and will abide by the guidelines listed above.

Signature of Shadow: _____

Date: _____

If Shadow is a minor (under 18 years of age):

I as parent or guardian of the above named minor do hereby consent to this minors participation in the shadow experience at Providence Alaska Medical Center. I agree to the provisions as listed above and adopt it as my own and agree to reimburse PAMC for any damage incurred by it for which this minor would be liable were he/she 18 years of age.

Signature of Parent or Guardian: _____

Date: _____

Printed name of Parent or Guardian: _____

Supervising Provider Attestation:

As supervising provider for this shadow, I will assume the responsibility for the shadow at PAMC. By placing my signature below, I understand that this shadowing experience at PAMC is intended to be strictly observational. I understand that the shadow is not permitted to touch patients/residents of any Providence Health & Services entity, handle patient resident care equipment and/or supplies as it relates to their care (this includes passing instruments). I understand that the shadow is not permitted to discuss patient/resident conditions with patients/residents and/or their family members, nor are they to discuss what he/she have heard/seen and/or learned during their shadow experience with anyone outside of those appropriate persons in the Providence Health & Services system. I understand that his/her doing so, may constitute a HIPAA privacy violation. I understand I have full responsibility for all actions or omissions of this shadow at PAMC. I understand I am responsible for the active supervision of this shadow. Should my supervising relationship with this Shadow change, I understand I am responsible to provide written notification to the Medical Staff Office that the relationship has changed.

Signature of Supervising Provider

Date



Providence Health & Services – Visitor & Temporary Staff Information Regarding Health Insurance Portability and Accountability Act (HIPAA)

HIPAA is a federal law that was passed in August 1996. Providence Health & Services Alaska (PHSA) must comply with HIPAA and as a temporary PHSA worker or visitor who may be exposed to patient information you are responsible for understanding and upholding this law. If you have questions or are unsure of the appropriate way to proceed please ask the department manager or your immediate supervisor.

Protected Health Information (PHI): Information that relates to the past, present or future physical or behavioral condition, care or payment of a patient and which identifies or could be used to identify a patient. It includes information in any form or media, including oral, written or electronic.

What You Need to Do:

- Access only the minimum amount of PHI needed to perform your job.
- Do not look up PHI about yourself or for family members, friends or neighbors.
- Do not talk about patients’ PHI with family members, friends or neighbors.
- Be aware of how you handle PHI in the course of your assignments.
- Be aware of who can hear your conversations.
- Dispose of paper PHI by shredding it or by placing it in secure recycling bins.
- Dispose of electronic PHI in a manner that will render the data unrecoverable.
- Never share or post passwords.
- Log off before leaving your workstation.

Privacy Rule:

- Gives patients more control over their PHI.
- Sets boundaries on use and release of PHI.
- Holds violators accountable with civil/criminal penalties.
- Allows some leeway for disclosing PHI in the best interest of the public.
- Enables patients to find out how their PHI may be used and disclosed.
- Limits release of PHI to the minimum needed for the purpose of the disclosure.

Criminal and Civil Sanctions: There are federal penalties for violation of HIPAA standards. These penalties could potentially be applied to both Providence Health & Services in Alaska and you as an individual.

How to Report Privacy Concerns: We appreciate your participation in helping us protect and keep patients PHI confidential. If you notice an area that needs improvement concerning patient confidentiality, please report it to the department manager or contact the Alaska region concern line to report issues to the Privacy Officer at 1-800-510-3375.

I understand & will abide to these standards:

Shadow Signature

Date

Shadow Printed Name

Parent or Guardian Signature (if minor)

Date

Parent or Guardian Printed Name (if minor)

