Reading Hospital
TOWER HEALTH
Advancing Health. Transforming Lives.

JOB SHADOWING PROGRAM APPLICATION

STUDENT INFORMATION

First Name: Last Name:

Age: Phone Number:

Email Address:

High School/College: Anticipated Graduation Year:

PARENT/GUARDIAN INFORMATION (IF UNDER 18 YEARS OLD)

First Name: Last Name:

Phone Number:

SHADOWING EXPERIENCE DETAILS

Career(s) and/or Department(s) of Interest:

Date	Start Time	End Time

Please provide **specific** dates and times that you can participate in a shadowing experience.

- Proposed shadowing dates should be submitted **at least 4 weeks prior** to the desired date of the experience to allow enough time for application review and approval and coordination of the experience.
- Job shadowing start and end times must fall between the hours of 7am-5pm.
- Job shadowing is not permitted on weekends unless otherwise discussed.
- Job shadowing hours may not be used to fulfill a requirement for academic credit or degree/program completion.

Note: International Medical Graduates, regardless of citizenship status, are not eligible to participate in Job Shadowing experiences.

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Below is a list of all documents required for a complete application. Please review this list and ensure you have all documents completed before submitting.

- ✓ Job Shadowing Application
- ✓ Signed Observer Acknowledgement: Non-Professional Observer Form
- ✓ Signed Statement of Confidentiality & Consent Form
- ✓ Proof of COVID vaccination
- ✓ Proof of influenza vaccination (for experiences scheduled between October 1-May 31)

All application documents should be submitted as attachments in one email to CommunityWellness@towerhealth.org. Application documents sent via cloud-based platforms (e.g., Google Docs) and incomplete applications will not be accepted.

ACKNOWLEDGEMENT

By signing this form, you agree to follow the Job Shadowing Program policies and procedures, as well as policies outlined in the Observer Acknowledgement and Statement of Confidentiality and Consent Forms.

Student Signature: _____

Parent/Guardian Signature: _____

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OBSERVER ACKNOWLEDGEMENT: NON-PROFESSIONAL OBSERVER

I understand and agree to the following shadowing requirements:

- I have provided the Hospital with identification indicating my age.
- I attest that I have a current health insurance plan which I will maintain throughout the entirety of my participation in the Job Shadowing Program.
- I will present a professional appearance (business casual dress or scrubs, as noted) while on campus.
- I have read and signed the Statement of Confidentiality and Consent.
- To my knowledge, I am free of known communicable diseases or acute health problems, and my immunization status meets my school requirements.
- I have provided proof of COVID-19 vaccination(s) and influenza vaccination (as applicable).
- I understand that I will not be examining patients or take part in any patient procedures, nor will I have access to any medical records.
- I will always remain with my Preceptor (or designee) during the entirety of the Job Shadowing experience.
- I will wear a visitor's badge while on campus which identifies me as a Student Observer.

I assume the risk of, and release and hold harmless Reading Hospital, Tower Health, and all other persons from any liability for physical or other injury that I may suffer during or as a consequence of participation in the Job Shadowing Program.

Intending to be legally bound, I have reviewed this form and agree to abide by it.

Print Name: _____

Signature: _____

Parent/Guardian Signature: _____

Date: _____

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STATEMENT OF CONFIDENTIALITY AND CONSENT

As consideration for allowing me to participate in the Job Shadowing Program at Reading Hospital, I acknowledge that I:

- Understand that my role as a participant is contingent upon compliance with all policies and rules of the Hospital.
- Recognize that, during my participation, I may become aware of private and confidential patient information through verbal, written, or electronic venues.
- Understand that I am required by law to keep this protected health information confidential.
- Agree to keep this information confidential and never to use or disclose it to others except as required for purposes of providing clinical care during Clinical Training and as permitted by the Health Insurance Portability and Accountability Act of 1996, as amended, and its implementing regulations set forth at 45 C.F.R. Parts 160 and 164, from time to time (collectively, "HIPAA").

I consent to substance abuse testing at the Hospital's expense as required by the Hospital while I am participating in the Program, and I understand that a failure of such test or refusal to comply with testing will result in termination of my participation in the Program.

Intending to be legally bound, I have reviewed this Statement and Consent, and agree to abide by it.

Print Name: _____

Signature: _____

Parent/Guardian Signature: _____

Date: _____