Application for Observational/Clinical Experience at Sebasticook Valley Health (SVH)

Complete numbers 1 through 11 of the application. Mail or fax completed application and all required forms to:
Laurie Alexander, Education Coordinator, SVH, 447 North Main St., Pittsfield, ME 04967 Fax: (207) 487-4591

- **A job shadow student must be 16 years of age. For students under 18 years old, a parent signature is required.**
- **Incomplete applications will be sent back and may hold up the processing time.**
- **If you have any questions, please call Laurie Alexander at (207) 487-3890, x 2731.**

Immunization: Participants enrolled in a Healthcare observational experience (not employed by a hospital) must provide proof of immunization for Rubella, Measles, Mumps and Chickenpox. Proof may be a note from the family physician, photocopy of immunization record, titers or a copy of records from high school or college.

1. **If you are NOT a healthcare worker or are NOT enrolled in a healthcare college program, please send proof of immunizations.**

2. Have you ever had the Chickenpox? ☐ Yes ☐ No **(Those without a history of chickenpox must show proof of immunity by official immunization records (2 doses) or a positive serum titer).**

3. **Influenza Vaccination (Sept-March) Please give Provider and date: ________________________________**
You will need an Influenza vaccination prior to coming for the shadow or clinical experience. If you decline to have the vaccination contact us for the correct declination form.

4.

Name:			
Address:	City:	State:	Zip:
Phone:		Cell:	
E-mail address:			
Name of employer or school:		Current grade level:	
Immediate supervisor/faculty member/advisor:			

5. Professional status: ☐ Student ☐ RN ☐ LPN ☐ Other (please describe): ________________________

6. Overall goal for observation/clinical experience at SVH:
____

7. Whom at SVH have you discussed your request for an experience with? ________________________

8. Desired start date with flexibility (final date to be determined by SVH) ________________________

9. Job Shadow desired time at SVH: ☐ 2-4 hrs ______________________________

10. Clinical experience for school (describe length time needed): ______________________________

11. Desired location or specialty to visit at SVH: __________________________________

The **SVH contact** for the department visited will need to close the tracking loop for each participant, by returning paperwork regarding the student to the education department.
Please contact the Community Health and Education department with the person's name and start date.

Laurie Alexander 487-3890 x2731 lalexander@emh.org

Page two of this application requires a signature

Observer/Student Code of Conduct and Confidentiality Statement

Code of Conduct

I have received a copy of the Sebasticook Valley Health /Eastern Maine Healthcare Systems Code of Conduct, the SVH notice of Privacy Practices and the Education on HIPPA Privacy at SVH. If I have any questions about these documents, I will ask my administrative contact for more information.

If I become aware of any possible violation of the Code or policy, I will report it as soon as possible. I can report violations to my administrative contact person, Director of Risk Management (ext 4028), the Compliance Officer (x 4022) or the EMH Employee Compliance Hot Line (1-866-621-2122).

Confidentiality

I will protect the patient's right to privacy--all information about the patient is confidential. I will not obtain, use or give out confidential information other than that directly related to my role as an observer/student. **I will not access my medical record, my family members or friends**. I will never mention a patient's name or illness to anyone outside of SVH. I will only discuss a patient's name or illness with my supervisor or the individuals involved in the patient's care if it relates to my role as an observer/student. As part of my experience, I may use, see or hear confidential patient and organizational information. The information may be verbal, written, on diagnostic equipment, on computer or tape. I will not obtain, use or give out confidential information unless I am required to do so as part of my experience.

If I am given or select a user name and password for accessing computers, voice mail or other electronic information systems at work, I will not tell anyone else what they are. My user name and password are the same as my signature and when used they mean that I obtained, used or gave out information. I am responsible for all activities if someone else uses my user name and password. I will contact my direct supervisor, the SVH Information Services Department (x 4048 or 4035) or the EMHS Security Officer (973-7047 x 7047) immediately if I believe someone else knows my password.

My use of SVH /EMHS computers, network and voice mail will be monitored by the SVH/EMHS Security Officers to make sure I follow the Code of Conduct and policies. If I use these systems off campus, I will make sure that I have privacy, my computer is secured to the standards required by SVH and EMHS and no one else can obtain confidential information. Anything I write or say using an SVH /EMHS computer or voice mail, and any attempt I make to use theses systems without permission can be reviewed by the SVH and/or EMHS security Officers.

I understand that I may be excluded from SVH Authorized Observer/Student Program at any time and without notice by the responsible SVH officials, if, in their sole discretion, they determine it to be in the best interests of SVH or its patients.

Student-Print Name: ______________________________ Signature: ________________________

Date: ________________________

Parent Signature: __________________________________ Date: ________________________

Laurie Alexander, Education Coordinator
Sebasticook Valley Health
447 North Main St.
Pittsfield, ME 04967

Office Phone #: 487-3890 x2731
Fax #: 487-4591
lalexander@emh.org

SVH Use Only

☐ Enter into database

Student Affiliation

☐ Job Shadow
☐ Clinical Rotation/Physician hosted student

Paperwork returned:

☐ Application
☐ Immunizations ☐ N/A
☐ Orientation
☐ Job shadow agreement
☐ Emergency notifications contacts

Send to: ____________________

Contact: __________ Dept. ________