



Dear Shadowing Participant,

Welcome to UCHealth North Shadowing Program! We are glad that you are considering a healthcare career. UCHealth is very proud of the service provided to our patients and we are honored to demonstrate that during your shadowing experience. We welcome questions prior to and during your time with us. The purpose of this program is to provide exposure and information for those who have an interest in exploring the medical field.

**There are a couple of items that we would like to emphasize before you begin:**

- **The shadow program is a *one-time observation only experience***, designed to help those who are deciding which career track to follow.
- You should apply for this program if you:
  - *Need to shadow one time only for two to eight hours based on departmental discretion*
  - *Want a beginning look at a healthcare field*
  - *Have been referred to our program by a career counselor*
  - ***Are 16 years or older***

Once you have decided on an area that you would like to explore, you can apply for the shadow program which will include completion of:

- Shadowing Program Application
- Non-Disclosure/Confidentiality Agreement
- Health Verification Form/Release of Responsibility (Proof of Immunization will be required)
- Contract to Participate in the Shadowing Program
- Parental Agreement (for shadow participants between 16-18 years of age)
- Evaluation of the program to be returned on completion of the shadow experience

We honor the privacy of our patients and it is very important that you read our Non-Disclosure/Confidentiality Agreement thoroughly. We are required by law to provide privacy to our patients and we take this responsibility seriously. This Non-Disclosure/Confidentiality Agreement is enclosed in your packet. This form will be reviewed by the volunteer office with you before you sign this document.

We want to ensure your comfort while you are at UCHealth. This is an **observation** experience only. Due to the nature of the healthcare environment, you may be exposed to unfamiliar situations. If you become uncomfortable or have any questions please let your sponsor know.

Please let us know if you have any questions. We hope that you have a wonderful experience and that you will let us know if you have any suggestions to improve this program.

Linda Fisher, MS, CAVS, CEL  
Regional Director, Volunteer/Guest Services

Shadow Contact Line and Information: (970) 870-1146



### HOW DO I SET UP A SHADOW EXPERIENCE?

This packet contains forms to be completed prior to your shadow experience. Please read thoroughly, complete required information, and include required immunization records. **It is your responsibility to contact Pam Bosch, YVMC Volunteer Services at 970-870-1146, to determine who the department sponsor is and if a shadow opportunity is available.** Once you have scheduled a shadowing session, you will schedule a time with Pam Bosch to return all completed paperwork and turn in your required medical documentation. Paperwork should be turned in at least one (1) week before your scheduled shadowing session. *If you do not bring in the all required documentation, you will not be able to shadow during your scheduled time and this could cause a 3 month delay at the discretion of the Volunteer Services Management.*

**Shadows may be cancelled at department discretion. No calls/no shows will not be rescheduled. If you are unable to attend the shadowing session, it is YOUR responsibility to contact the sponsor to reschedule.**

### WHAT IS THE SCHEDULE FOR YOUR SHADOW DAY?

The Shadow experience begins at the main entrance to the facility where your shadowing experience will take place (please arrive about 10 minutes prior to your shadow time). If you are more than 15 minutes late, you will not be able to shadow that day. Your sponsor or a representative from the department will meet you and escort you to the area where you will be shadowing. They will provide you with a badge which must be worn during your shadowing experience.

**A Picture ID will be required.** At the end of your shadowing session, the badge must be returned to the sponsor.

### WHAT SHOULD I WEAR?

Refer to the following dress code policy.

PLEASE NOTE: The entire UCHealth campus is a smoke-free, drug-free environment that promotes the health and safety of patients, visitors, and our workforce

### DRESS CODE

Participants of the UCHealth Shadowing Program shall dress appropriately to promote safety, credibility, and a professional image to our customers. **PLEASE do not wear jeans or you will not be able to shadow.**

- Clothing is to be modest and should not be inappropriately revealing, form fitting, or expose the midriff. Examples that do not fit the intent of this policy include tank tops, spaghetti straps, leggings, shorts, and t-shirts with words, pictures, or non-UCHealth logos.
- All clothing should be neat and clean.
- For the comfort of patients and visitors, all shadowing participants must be free of any detectable odor of smoke.
- No perfumes, scented lotions, or after-shave.
- Earrings are the only visible body-piercing jewelry allowed. No facial or tongue jewelry is allowed. A maximum of three earrings per ear is allowed. Excessive jewelry is not permitted due to safety and hygiene issues. Tattoos that are excessive or have an inappropriate nature must be covered.
- Wear clean, quiet comfortable shoes. Open toed shoes are not allowed.
- Wear your shadowing badge at all times.

Exceptions to this policy may be based on a particular departmental need as authorized by management.

**The goal for all shadowing participants is to dress appropriately for our patients and our work areas. If a participant reports for shadowing in unacceptable attire, is poorly groomed, or there is a patient complaint, the sponsor will instruct the participant to leave.**



## Shadowing Application

Name \_\_\_\_\_

Current Mailing Address \_\_\_\_\_  
Street City State Zip

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

E-Mail Address \_\_\_\_\_

\*You must be at least 16 years of age. Parental agreement must be completed if you are between the ages of 16-18.

### Emergency Contact:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

### Shadowing Sponsor Information:

Department Contacted: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Date of Shadow: \_\_\_\_\_

### Personal Survey:

Are you personally acquainted with a UCHealth volunteer or employee at this time? If yes:

Name: \_\_\_\_\_ Dept: \_\_\_\_\_ Phone: \_\_\_\_\_

Are there any work activities or conditions that you must avoid? \_\_\_\_\_

Have you ever been convicted of any law violation? Include a plea of guilty or no contest. Exclude minor traffic offenses. Yes No

If yes, explain:

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(Signature)

YVMC Volunteer Office Approval:

<input type="checkbox"/> Non-Disclosure/ Confidentiality Agreement	<input type="checkbox"/> Agreement to Participate
<input type="checkbox"/> Health Verification Form/Release of Responsibility	<input type="checkbox"/> Parental Agreement
<input type="checkbox"/> Immunization Record/Proof of TB Test	



# HEALTH VERIFICATION FORM RELEASE OF RESPONSIBILITY

I am aware of the risks involved with a shadowing experience at UCHealth Yampa Valley Medical Center.

I confirm that I have current immunizations for:

1. Measles/Mumps/Rubella (2 MMR's needed)
2. PPD (TB) within the last year or negative chest X-Ray.
3. Current Influenza Vaccination for any shadow scheduled during flu season. (Must be administered after September 1 of the current flu season).

**(A copy of these immunizations record are required. Please attach with this form.)**

**Any costs I incur as a result of my shadow experience will be my responsibility.**

Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If a MINOR (between 16-18): \_\_\_\_\_ Date: \_\_\_\_\_  
Signature Parent/Guardian

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_



**NON-DISCLOSURE/CONFIDENTIALITY AGREEMENT**

As a shadow program participant, I understand that I may come in contact with confidential information, both patient and employee-related, through written records, documents, ledgers, internal verbal correspondence and communications, computer programs and applications.

I agree not to disclose this confidential information to anyone other than those persons at UCHealth that I am working with during my shadow experience.

I will not access, use or disclose this confidential information for any reason outside of my shadowing experience.

I will be responsible to secure confidential information in the work vicinity, dispose of confidential material in instructed areas and return confidential access codes/badges upon the end of my shadowing experience.

I understand the shadowing session is voluntary and I do not expect compensation.

I acknowledge that in the event I breach any provision of this agreement, UCHealth, in addition to any other legal remedies available to it, has the right to reprimand, suspend and/or dismiss me from the shadowing session.

**Do not sign this agreement until you are in the presence of a Volunteer Services Representative.**

Shadow Participant Name (please print) \_\_\_\_\_

Signature\_\_\_\_\_

Witness Signature\_\_\_\_\_

Date:\_\_\_\_\_



## Agreement to Participate in the Shadow Program

### 1.0 INTRODUCTION

This Agreement provides for a supervised short term educational experience at UCHealth, covering individuals shadowing at UCHealth who will not be engaged in any form of patient care or hospital procedures, either clinical or non-clinical in nature.

### 2.0 SHADOW EXPERIENCE TIME FRAME

The shadow experience will occur on the \_\_\_\_\_ day of \_\_\_\_\_ 201\_, between the hours of \_\_\_\_\_ to \_\_\_\_\_ . Location of Shadow: \_\_\_\_\_

### 3.0 EMPLOYMENT STATUS

Both parties agree that the individual participating in this shadowing experience is an observer, and is not an employee of UCHealth while participating in this program. If the individual is an employee of UCHealth who wishes for a shadowing experience, he or she must participate on their own time and follow all procedures of this policy as if they were not a UCHealth employee. Participation in this program is solely for the purpose of engaging in an educational shadowing experience.

### 4.0 RESPONSIBILITIES OF UCHEALTH

UCHealth will provide a supervised educational shadowing experience according to agreed upon objectives. UCHealth retains the right to terminate the shadowing experience when violations of UCHealth rules, regulations, policies or procedures occur. UCHealth reserves the right to take immediate action when necessary to maintain operation of its facilities free from interruption. In the event of an onset of illness or injury during the shadow experience, appropriate emergency care, as provided to visitors, will be provided to the shadowing participant by UCHealth. The shadow participant will be liable for the cost of such care and obtaining appropriate follow-up care, if needed. The shadow participant must be accompanied by a sponsor who agrees to supervise the shadowing experience at all times.

### 5.0 RESPONSIBILITIES OF THE SHADOW PARTICIPANT

The individual coming to UCHealth for shadow experience is required to do the following:

- Arrange the shadow experience in advance through the Volunteer Office at UCHealth, and then make the arrangement with the designated sponsor.
- Complete the UCHealth shadowing application packet and provide copies of immunization records. All participants must schedule an appointment with YVMC Volunteer Services to turn in completed paperwork.
- Dress in conservative, appropriate attire: no shorts, no open toed sandals, no short skirts, t-shirts or jeans. Sweat suit apparel and logo clothing, hats, perfume, after shave lotion or heavy jewelry is not permitted. No odor of smoke permitted.
- Wear a hospital issued name badge at all times while on the premises.
- Obey instructions by sponsor while on the premises.
- Defer from participating in the shadow program when experiencing an infectious disease condition including, cough, runny nose, sneezing, sore throat, rash, flu, diarrhea, vomiting, or when other diseases that are communicable are present.
- Silence cell phone at all times. Agree not to take photos, video tape, or tape record any conversations while on UCHealth premises.

It is understood that the shadow experience at UCHealth must not interfere with the primary mission of the care and treatment of patients, which shall remain the responsibility of UCHealth. The shadow participant is required to adhere to UCHealth rules, regulations, policies and procedures while on its premises, including all policies related to confidentiality, patient rights and responsibilities, and ethical conduct.

### 6.0 COMPLIANCE WITH LAWS AND REGULATIONS

Services covered by this agreement shall be and shall remain in compliance with the Health Information Portability and Accountability Act, all applicable federal, state and local laws and regulations, and The Joint Commission on Accreditation of Healthcare Organizations standards.



## 7.0 CONFIDENTIALITY

Performance of health care services includes a duty by UCHealth to safeguard certain information, including, but not limited to patient information, from inappropriate disclosure. Therefore access to such information shall be strictly limited to shadow participants. Participants in this shadow experience may not review confidential patient information.

## 8.0 PARTICIPANT REQUIREMENTS

Participant attests to the conditions of this contract for shadow participation by signing the agreement below:

1. I will be observing only for educational purposes as a participant in the shadow program.
2. I will not take any photographs, video or audio recordings during my experience.
3. I have reviewed and signed the Non-Disclosure/Confidentiality Agreement.
4. I will not share my shadow experience on social media.
5. I do not have a cold, fever, or communicable disease that would pose a health risk for others.
6. I will be dressed appropriately per the guidelines of the shadow program.
7. I understand if I am more than 15 minutes late, I will not be able to shadow that day.
8. I agree to comply with any requests by UCHealth personnel or credentialed MDs to ensure patient safety and confidentiality.
9. I agree to be guided by an employee of UCHealth regarding policies and procedures of UCHealth and the appropriateness of my observation of aspects of their role. My signature releases UCHealth from liability for claims for loss or injury.

X \_\_\_\_\_  
**Print Name**

X \_\_\_\_\_  
**Signature** **Date**

## SPONSOR REQUIREMENTS:

1. I will meet the participant in the designated area to pick him/her up at the start of his/her experience (or send an identified designee).
2. I will keep the participant under my supervision at all times during their shadowing experience.
3. I will respect patients and/or family's wishes regarding privacy and exclusions from being observed.
4. I will ensure the participant is returned to the designated area at the close of the shadow experience, make sure they return their badge and complete a brief evaluation form.
5. If at any time the shadow participant is not behaving appropriately per UCHealth policies and procedures, the shadow participant must be dismissed from the shadowing experience. In this situation, as their sponsor, I will:
  - o Escort the participant back to the designated area and retrieve the participant's badge.
  - o Escort participant out of the facility to ensure the participant is no longer in the hospital/clinic environment.
  - o Contact the Volunteer Services department to document the circumstances of the dismissal.
  - o Once shadowing participant has signed this agreement, contract will be emailed to the contact person listed by department to retain for their records. Shadow sponsor will abide by the shadow policy and procedures within the guidelines of this program.



# Parental Agreement

I give my consent for my son/daughter, age 16 to under 18, to participate in the UCHealth Shadowing Program.

1. I will assist and encourage him/her in fulfilling the responsibilities of applying to the program; including keeping his/her commitment.
2. I will assist in arranging transportation to and from the hospital.
3. Both my child and I realize that shadowing is my child's responsibility and should be taken very seriously. We understand that he/she must follow all rules and regulations established and that UCHealth will be depending on him/her to be here on the day on which he/she is scheduled to shadow (two to eight hours only based on departmental discretion). I will encourage my son/daughter to communicate with the sponsor directly, as he/she is responsible for their shadowing activity.
4. I am aware that UCHealth reserves the right to dismiss my son/daughter's from shadowing under the following circumstances:
  - A. Failure to comply with UCHealth policies and procedures.
  - B. Personal conduct, attitude, or appearance.

I HEREBY GIVE MY PERMISSION FOR MY SON/DAUGHTER \_\_\_\_\_  
(NAME)

- a) To participate in the UCHealth Shadowing program.
- b) Have minor emergency treatment by the Hospital, if necessary.

This consent shall remain effective as long as the above named participant is under the direction of a department sponsor of the hospital and is under 18 years of age, unless sooner revoked in writing and delivered to the hospital.

\_\_\_\_\_  
Signature of Parent or Guardian Date

Name (Print name): \_\_\_\_\_

Phone number: \_\_\_\_\_

Relation to Participant: \_\_\_\_\_





**EVALUATION OF SHADOW EXPERIENCE**  
(Return to YVMC Volunteer Services)

Date of Shadow \_\_\_\_\_

Start Time \_\_\_\_\_ End Time \_\_\_\_\_

Unit \_\_\_\_\_

Sponsor Name \_\_\_\_\_

Score your shadow experience 1 to 5 with 5 being the best on the following questions:

- 1. It met my expectations and goals    1 2 3 4 5
- 2. Hospital staff was friendly and welcoming    1 2 3 4 5
- 3. My questions were answered    1 2 3 4 5

Please use the following space to let us know any specifics about your shadowing experience or any ways that we could have improved your experience:

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Please let us know if you would like any additional information:

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