Medical/Intern Checklist

Name:

ALL:

- ☐ Completed Application
- ☐ One Page Statement of what you hope to gain from shadow experience
- ☐ Information Confidentiality
- ☐ Employee Confidentiality
- ☐ GEAR Answer Sheet (Use the link to the GEAR book to complete the GEAR answer sheet)
- ☐ Job Shadow Waiver of Liability and Health Form
- ☐ Flu Shot/exemption (in season), Required October to March
- ☐ Proof of a two-step Mantoux (TB) test within the past year
- ☐ Immunization records
- ☐ Student Observer Agreement Form
- ☐ Emergency Contacts

Intern Additional:

- ☐ Confirmed Affiliation Agreement Between School and Baptist Hospitals of Southeast Texas

Medical Observers Additional Forms:

- ☐ Privileged Physician Sponsor Agreement
- ☐ CVS/ Resume

All Completed Forms Attached

_____ _____

Signature Date

Baptist Hospitals of Southeast Texas

Performing Sacred Work Every Day

Medical Observer/Intern* Application

** for Affiliation Agreements only*

JOB SHADOW INFORMATION

The Medical Observer/Intern Program is an observation only experience in a select department within Baptist Hospital based on availability. The participant will have an opportunity to observe and interact with a healthcare worker as they go about their daily activities. Hands-on patient care isn't part of the Medical Observer/Intern Program and will not be permitted. The purpose of the Medical Observer/Intern Program is to foster an awareness of the skills required for a specific career and to experience healthcare culture. This program was developed to assist college students meet observation experience requirements to gain admittance into an academic program. Participants must be 18 years of age or older. Those younger than 18 years of age can inquire about our student volunteer program through our volunteer department.

GUIDELINES FOR JOB SHADOW

- Participants must fill out all required forms completely including Job Shadow Application, Waiver of Liability and Health Form, GEAR testing and the Confidentiality Agreements along with the Medical Observation/Intern Checklist.
- It is required that you have the following before observation/internship can start:
    - Influenza vaccine in the current season when participating in a job shadow experience from October 1st through March 31st of each year.
    - Verification of a two-step Mantoux (TB) testing is required.
    - A record of your immunizations or titers provided on acceptance.

Two-step TB testing and Influenza vaccination can be performed by Baptist Employee health for a non- refundable fee of $75.

There is a 30 day job shadowing limit only in many clinical areas.

APPLICATION PROCESS

- Priority for registration will be given to first time participants and applications will be processed on a first come, first served basis.
- We will do our best to meet your department observation request but if we cannot meet the request, we will contact you and let you know.
- Email the application and completed forms to
- All required forms must be complete on receipt. Incomplete forms will place your request at the end of the submission list. One application per participant.
- You will receive an email or call regarding your application and next steps that will need to be taken.
- All applications are held for a period of 60 days.
- If chosen for the program, a non-refundable application fee of $25 must be paid before the start of the observation.

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Medical Observer/Intern* Application

** for Affiliation Agreements only*

MEDICAL OBSERVER/INTERN APPLICATION FORM

Today's Date: _____

First Name: _____ Last Name: _____ DOB: ___/___/___
(Month/Day/Year)

Address: _____

City: _____ State: _____ Zip: _____

Telephone (with area code): _____

Email address: _____

Name of Emergency Contact: _____

Emergency Contact Phone Number: _____

EDUCATION

College/Other Affiliation _____

Student year: _____

List your first choice for observation. _____

List second are of interest in case your first choice is not available. _____

How many hours of observation are needed.

Is this observation request a requirement for admission to a specific school program?

Name of school. _____

Have you ever been convicted of a felony or are you awaiting trial for a felony? _____

Along with the application, in one pager or less, tell us what you are hoping to learn or gain during this job shadow experience, and a list of your objectives.

Baptist Hospitals of Southeast Texas

INFORMATION CONFIDENTIALITY AGREEMENT

Computerized information systems are one of the Hospital's most valuable assets. Our success and the privacy of our patients depend on the protection of this information against theft, destruction, misuse or disclosure to outside interest.

Employees, physicians, consultants and vendors may be responsible for operating computer equipment or accessing software systems as part of their performance or duties for Baptist Hospitals of Southeast Texas. Those persons must understand and follow the information security policies in effect for the Hospital.

Therefore, I agree to the following provisions:

- Not to operate or attempt to operate computer equipment without specific authorization form supervisors.
- To access only computer systems, equipment and functions as required for the performance of my responsibilities. Electronic games of any kind are expressly prohibited.
- To use hospital email and internet services to facilitate Hospital business only.
- Not to demonstrate the operation of computer equipment to anyone without specific authorization.
- Not to install software, add inappropriate information, or alter information without specific authorization from supervisors.
- To maintain assigned passwords that allow access to computer systems and equipment in **strictest** confidence and not disclose a password to anyone, at any time, for any reason.
- To contact my supervisor immediately and request a new password(s) if mine is (are) accidentally revealed.
- Not to record passwords in any manner, as this increases the possibility of accidental disclosure.
- To appropriately log off the computer system before leaving the area so that no one else can access the system with my password.
- Not to disclose any portion of a patient's record except to a recipient designated by the patient or to a recipient authorized by the Hospital who has a need-to-know in employment or other service obligation to the Hospital.
- To report activity that is contrary to the provisions of this agreement to my supervisor of the Information Technology department.

I understand that failure to comply with the above policies will result in formal disciplinary action, up to and including termination from the Hospital in the case of employees and the termination or cancellation of agreements in the case of physicians, consultants, or vendors.

By signing the Acknowledgement of Employment Packet, I acknowledge that I have reviewed and understand the above listed policies and agree to abide by them. I further understand that I am expected to use these policies for general guidance and to seek additional information from my supervisor or the Human Resources Department if needed.

_____ _____

Employee/Physician/Consultant/Vendor Signature Date

Baptists Hospitals of Southeast Texas
Employee Confidentiality Agreement

IMPORTANT: Please read all sections. If you have any questions, please ask before signing.

1. **Confidentiality of Patient Information**
   I understand and acknowledge that: (i) services provided to patients are private and confidential; (ii) to enable such services to be performed, patients provide personal information with the expectation that it will be kept confidential and used only by authorized persons as necessary; (iii) all personally identifiable information provided by patients or regarding medical services provided to patients, in whatever form such information may exist, including oral, written, printed, photographic and electronic formats (collectively, the "Confidential Information") is strictly confidential and is protected by federal and state laws and regulations that prohibit its unauthorized use or disclosure; and (iv) in the course of my employment with Baptists Hospitals of Southeast Texas, I may be given access to certain Confidential Information.

2. **Disclosure, Use and Access**
   I agree that, except as authorized in connection with my assigned duties, I will not at any time use, access or disclose and Confidential Information to any person (including but not limited to co-workers, friends, and family members). I understand that this obligation remains in full force during the entire term of my employment and continues in effect after such employment terminates.

3. **Confidential Policy**
   I agree that I will comply with confidential policies that apply to me as a result of my employment.

4. **Return of Confidential Information**
   Upon termination of my employment for any reason, or at any other time upon request, I agree to promptly return to Baptist Hospitals of Southeast Texas all copies of Confidential Information then in my possession or control (including all printed and electronic copies).

5. **Periodic Certification**
   I understand that I am required to certify each year that I have complied in all respects with this Agreement.

6. **Remedies**
   I understand and acknowledge that (i) the restrictions and obligations I have accepted under this Agreement are reasonable and necessary in order to protect the interests of patients and Baptist Hospitals of Southeast Texas. I therefore understand that Baptist Hospitals of Southeast Texas may prevent me from violating this Agreement by any legal means available, in addition to corrective measures, which may result in accordance with applicable policies and collective bargaining agreements.

_____ _____

Signature Date

_____ _____

Printed Name Social Security Number

Name: _____

Employee Number: _____

Date: _____

GEAR Module Answer Sheet

General Education & Annual Requirements For All Employees

This symbol in the ***GEAR*** module identifies the quiz questions that you are to answer as proof of completion of that portion of the module. Select the answers to each of these quizzes on this answer sheet by choosing the correct letter choice or typing the correct answer where it applies. This module is **MANDATORY** for all employees who work for **Baptist Hospitals of Southeast Texas** regardless of job status.

PIC/Customer Service:			
	A	B	C
1			
2			
3			
4			

Patient Rights:			
	A	B	C
1			
2			
3			
4			
5			

Institutional Ethics Committee:		
	T	F
1		
2		
3		
4		
5		

Cultural Awareness:			
	A	B	C
1			
2			
3			
4			
5			

Performance Improvement:			
	A	B	C
1			
2			
3			

Infection Control:			
	A	B	C
1			
2			
3			
4			
5			
6			

Fire Safety:			
	A	B	C
1			
2			
3			
4			
5			

General Safety:			
	A	B	C
1			
2			
3			
4			
5			
6			

Hazardous Materials:			
	A	B	C
1			
2			
3			
4			
5			

NBC Emergency Preparedness:			
	A	B	C
1			
2			
3			
4			

MRI Safety:		
	T	F
1		
2		
3		
4		
5		
6		

Radiation Safety:		
	T	F
1		
2		
3		

	A	B	C
4			

Risk Management:			
	A	B	C
1			
2			
3			
4			

Back Safety:			
	A	B	C
1			
2			
3			
4			
5			

Corporate Compliance:			
	A	B	C
1			
2			
3			
4			
5			

HIPPA:			
	A	B	C
1			
2			
3			
4			
5			

Age Appropriate:			
	A	B	C
1			
2			
3			
4			
5			

Abuse and Neglect:			
	A	B	C
1			
2			
3			
4			

Suicide Prevention:		
	T	F
1		
2		
3		
4		
5		

Baptist Hospitals of Southeast Texas
Performing Sacred Work Every Day

Medical Observer/Intern* Application

** for Affiliation Agreements only*

JOB SHADOW WAIVER OF LIABILITY AND HEALTH FORM

For and in consideration of the participation of _____ (name of participant) in the Baptist Hospitals of Southeast Texas Medical Observer/Intern program., I for myself, my heirs,, executors, administrators, successors and assigns; do herby release, acquit and forever discharge Baptist Hospitals of Southeast Texas, its agents, employees, and all other persona who might be liable from any and all causes of action, claims and demands of whatsoever nature and kind whether known or unknown arising from my participation in said Program. Further, I for my heirs, successors, administrators, executors and assigns do hereby covenant not to bring any action against Baptist Hospitals of Southeast Texas, its agents, employees and all other persons providing services in the Program and agree to indemnify and hold harmless the same in the event any such action is hereafter brought, or claim is hereafter made.

It is further understood and agreed that I, for my heirs, successors, administrator and assigns, do hereby agree to indemnify and hold Baptist Hospitals of Southeast Texas, its agents, employee, and all other persons, providing services in the Program with respect to any potential subrogation claims by any and all third party payors with respect to payments made to the Hospital or any other health care medical providers for health care with respect to any injuries sustained in the course of my participation in the Program.

The release contains the entire agreement between the parties hereto, and the terms of this release are contractual and not a mere recital. I further state that I have carefully read the foregoing release and know the content hereof, and I sign my name as a free and voluntary act. I, the undersigned medical observer/intern, do hereby acknowledge that I have read and understand the following statements.

I agree to abide by and be bound by the following statements in return for Baptist Hospitals of Southeast Texas allowing me to participate in the Medical Observer/Intern Program.

1. I will conduct my Medical Observer/Intern activities at Baptist Hospitals of Southeast Texas under the supervision of a Baptist Hospitals of Southeast Texas employee or Privileged Physician.
2. I will comply with all Baptist Hospitals of Southeast Texas rules and regulations, polices and procedures, behavior standards and rules of conduct outlined in the application.
3. I understand that Baptist Hospitals of Southeast Texas retains the right to remove any Medical Observer/Intern at any time.
4. I acknowledge that I am not an employee of Baptist Hospitals of Southeast Texas during the Program.
5. I understand that I am responsible for the coast of any medical care that I receive at Baptist Hospitals of Southeast Texas for any reason.
6. I acknowledge my responsibility and liability regarding the confidential nature of all information that I have access to at Baptist Hospitals of Southeast Texas by virtue of my participation in this program.
7. I understand that I may not participate in the Medical Observer/Intern Program until all required paperwork, background reports and medical requirements are completed, and any fees are paid.

Participation in the program is prohibited unless this Waiver is signed by the Medical Observer/Intern.

_____ ----------

Participant's printed name

Witness printed name.

_____ _____

Participants' Signature/ Date

Witness Signature/ Date

Observer/Shadow Agreement Form

I agree that as an observer I will not be involved with, assist with, or participate in any patient care. I understand that even if my physician permits any kind of patient that I am not allowed to do so. I will not perform any functions independently and understand that I must be accompanied by my clinician or physician sponsor(s) at all times. I understand that I may view patient records with my sponsoring physician(s) but cannot access them independently or make any notations/edits to the patient record. I agree that I will not touch any patient or perform any tasks independently concerning patient care.

Observer:

_____ _____

Printed Name Signature

_____

Date

Sponsor:

_____ _____

Printed Name Signature

_____

Date

EMERGENCY CONTACT FORM

PLEASE PRINT

NAME: _____

ADDRESS: _____

_____

IN CASE OF AN EMERGENCY, PLEASE CONTACT THE FOLLOWING PERSON(S):

NAME: _____

ADDRESS: _____

_____

HOME PHONE: _____ **WORK PHONE:** _____

EMPLOYER: _____

RELATIONSHIP: _____

NAME: _____

ADDRESS: _____

_____

HOME PHONE: _____ **WORK PHONE:** _____

EMPLOYER: _____

RELATIONSHIP: _____

Physician Sponsor Agreement – Student Observer/Shadow

To whom it may concern,

I agree to sponsor, _____, who has requested permission to shadow me during my surgical/medical rounds at Baptist Hospitals of Southeast Texas. The above student plans to pursue a career in healthcare and would like the opportunity to expand his/her exposure to the field of medicine/surgery. I understand I am solely responsible for the student's supervision during his/her time of observation.

_____ _____

Sponsoring Physician Signature *Date*