Career Shadow Application

Thank you for your interest in SVMC's Career Shadow Program! Please complete the following information to participate in the program.

Today's Date: __________________

Name:____

Address: ____________________________ City _______________ State ____ ZIP _________

Education Status

List highest level of education completed, school, dates, and course of study: ___________________

____

Are you currently enrolled in school? No Yes

Name of School/College__________________________ Estimated Completion Date: _____________

Department/Unit/Healthcare Profession of 1st choice: ______________________________________

2nd choice: ____

Dates of Preference You are Available to Shadow: __________________ ___________________ ________________

Please explain why you want to shadow a health professional at SVMC:

NOTE: Please understand SVMC will make every effort possible to accommodate your job shadowing experience based on your preferences. However, we reserve the right to modify and/or cancel any shadow experience in the best interest of our operations and patient care services. You will be notified if any changes are made in advance.

Shadow Applicant's Signature: _______________________________ Date: ___________________

Please return the completed Career Shadowing Packet to: SVMC Human Resources, Attn: Recruiter

<u>To Be Completed by SVMC HR Department</u>:

Department Assignment: ____

Assigned Staff: ____

Shadow Date(s) ____

HR Signature: ____Date: ________________

Sierra View Medical Center (SVMC) Career Shadowing Observer Agreement

I, ___________________________________ have requested a Career Shadow experience at SVMC.

- I have read and understand the Expectations of an Observer. I agree to comply with all SVMC policies and procedures and all SVMC staff instructions during my shadow experience.
- I understand that I cannot provide any direct patient care or manipulate any of the equipment used for patient care.
- I understand that I will be participating in the Career Shadow Program on my own time and will not be compensated by SVMC for my time spent shadowing. I also understand that I cannot disrupt my departments operations by scheduling a shadowing experience during my normal and regularly scheduled work hours.
- My signature indicates that I have read and understand this form, have all necessary immunizations, and that I release SVMC from all liability claims for any loss or injury arising from this experience.

____ ____________
Observer Signature Date

SVMC Mentor and Staff Being Observed Agreement

I,____ will guide this individual through an observation experience related to the work I do. I will respect my patient's/family's wishes regarding privacy and exclusions from being observed. I will inform the observer of all customary precautions, including applicable policies and procedures, which apply to this experience. I will assure that the observer does not provide any direct patient care, does not touch the patient, and does not manipulate any equipment used in patient care.

____ ___________
SVMC Mentor/Supervising Staff Member Date