West Holt Medical Services

JOB SHADOW REQUIREMENTS

The West Holt Medical Services' job shadow program is a great way to gain a better understanding of a career in healthcare. This opportunity is available to ages 16 and above.

Our job shadow experience is a one day, 4-8 hour observation of a specific healthcare career or department within West Holt Medical Services.

In order to participate in the WHMS Job Shadow Program you will need to submit the following documents to our marketing department for approval:

- ☐ Produce a copy of current Flu Shot if available.
- ☐ Job Shadow Application
- ☐ Photo & Video Release Form
- ☐ Release of Liability Form

Please return all documents listed above to:

West Holt Medical Services
Attn: Marketing Department
406 West Neely Street
Atkinson, NE 68713

OR

Email the Marketing Department at marketing@westholtmed.org

Every effort will be made to accommodate your requested dates/times and department preferences. However, please know that we reserve the right to deny a request at our discretion. We do not allow shadowing of high risk areas including: Surgery, Laboratory, Imaging or areas where isolation precautions are in place.

Once your application has been reviewed and approved, you will be contacted by the team leader of the department you have requested to job shadow with. This process may take up to two weeks. The day of your shadow experience a brief orientation will be conducted with the Team Leader to sign additional required documents.

If you have any other questions regarding our job shadow experience, please contact the Marketing Department at (402) 925-1956.

West Holt Medical Services

JOB SHADOW APPLICATION

NAME: _____ DOB & AGE: _____

MAILING ADDRESS: CITY & STATE: ZIP CODE:

_____

CELL PHONE: _____

EMAIL ADDRESS: _____

HIGH SCHOOL / COLLEGE: _____

INTENDED CAREER / MAJOR: _____

EMERGENCY CONTACT

NAME: _____ PHONE: _____

THE FOLLOWING AREAS ARE AVAILABLE SHADOWING:

Please select the area you wish to shadow (choose 1)

_____ NURSING
_____ HOSPITAL ADMINISTRATION
_____ NURSING
_____ PRIMARY CARE CLINIC PROVIDER
_____ INFORMATION TECHNOLOGY
_____ MEDICAL RECORDS
_____ SPECIALTY CLINIC PROVIDERS
_____ NUTRITIONAL SERVICES
_____ OCCUPATIONAL THERAPY
_____ PHARMACY
_____ PHYSICAL THERAPY
_____ RESPIRATORY THERAPY
_____ SOCIAL SERVICES
_____ BUSINESS OFFICE

EMPLOYEE YOU WISH TO SHADOW: _____

WHY DO YOU DESIRE TO SHADOW THIS AREA / POSITION?

_____
_____
_____
_____

DATE YOU WISH TO SHADOW: (Please list in the order of preference)

1. _____ 2. _____ 3. _____

HR_Procedure_Onboarding/Offboarding
MKT_Form_Job Shadow Photo & Video Release
MKT_Form_Job Shadow Release of Liability
MKT_JA_Job Shadow Requirements

West Holt Medical Services

AFFIRMATION AND RELEASE OF LIABILITY

I, the undersigned, do hereby acknowledge that I am cognizant of and understand that there are inherent dangers in participating in the West Holt Medical Services' Student Job Shadow Program, which includes, but is not limited to encountering experiences which may be relatively new and may be taxing on the senses and also being around an environment that has sick and/or injured patients.

In consideration of participating in this program, I hereby assume all risk in connection with any of the above mentioned activities, situations and to being present at any of the facilities of West Holt Medical Services. I hereby release West Holt Medical Services, its administration, board of directors, employees, and agents from any and all liability related to participation in the West Holt Medical Services' Student Job Shadow Program.

I further state that I am I am of lawful age, and I am competent to sign this Affirmation and Release of Liability form; that I understand the terms herein are contractual, and not a mere recital; and that I have signed this document as my own free will. I am fully informed of the contents of this Affirmation and Release of Liability, as I have read it before I have signed it.

_____ _____
Signed Date

_____
Print Name

Under 19 years of age, a parent or legal guardian signature is required.

I hereby give permission for my child to participate in the West Holt Medical Services' Student Job Shadow Program and have read and agree to the above statements.

_____ _____
Parent / Legal Guardian Signature Date

_____
Print Name

HR_Procedure_Onboarding/Offboarding
MKT_Form_Job Shadow Application
MKT_Form_Photo & Video Release
MKT_JA_Job Shadow Requirements

West Holt
Medical Services

PHOTO & VIDEO RELEASE

I, the undersigned, do hereby consent and agree that West Holt Medical Services, its employees, or agents have the right to take photographs, videotape, or digital recordings of _____ and release all rights to exhibit this work in print and electronic form publicly or privately.

Signed: _____ Date:_____

Print Name: _____

Under 19 years of age, a parent or legal guardian signature is required.

_____ Date: _____

Parent / Legal Guardian Signature

_____

Print Name

_____

Phone Number