PROVIDENCE
St. Mary
Medical Center

401 W. Poplar Street | Walla Walla, WA 99362 | (509) 897-2820 | Program Development Coordinator|

PSMMCjobshadows@providence.org

OBSERVATION APPLICATION

Last Name _____ **First Name** _____ **Middle Initial** _____

Current Residence Address _____ **City/State/Zip** _____ **Phone** _____

Birth Date _____ **E-mail address** _____

School or Affiliation (if applicable) _____ **Instructor Name (if applicable)** _____ **Phone** _____

School City/State _____

OBSERVATION GOALS

Which department/professions would you like to shadow or what are your areas of interest (RN, Ultrasound, Emergency Department, Primary Care etc.)

_____

Have you already been in contact with a PSMMC caregiver regarding your shadow request? If yes, who?

_____

Why are you interested in the observation/job shadow experience?

_____

How many hours are you requesting to observe here at PSMMC?

_____

Please list any health problems or allergies you may have including any allergies to food, drugs and/or latex:

_____

Please list any medications you are currently taking:

_____

Please list any individuals to be contacted in an emergency:

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

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MINOR AUTHORIZATION
(For High School Students)

I, (PRINT)_____, am the parent/guardian of _____.

I understand that my son/daughter would like to participate in an Observational Job Shadow at Providence St Mary Medical Center.

I agree that (PRINT)_____ may participate in the Observational Job Shadow Program at Providence St Mary Medical Center and that they will abide by all policies, procedures and regulations that will affect them as an observer.

I am aware of the possibility of person health and safety risks due to my child's participation in the job shadow experience, including the exposure to potentially infectious blood or other body fluids. I assume all risks, hazards, and injuries incident to such participation and do hereby waive, release, absolve and agree to hold harmless Providence St Mary Medical Center and its staff from any claim arising out of an illness or injury to my child.

In the event of injury or accident while at Providence St Mary Medical Center, I understand that my son/daughter will be taken to the Emergency Department for assessment and evaluation as needed and that I will be notified. I understand that I am responsible for any expenses incurred as a result of the Emergency Department visit.

_____	_____	_____
Parent/Guardian Signature	Cell Phone #	Date

ACKNOWLEDGEMENT

I agree that I have read, understand and will abide by the information outlined in the Orientation Requirements. I understand that I am responsible for abiding by the Providence St. Mary Medical Center policies in relation with this material and my experience. I also understand if I have not completed this application in its entirety, it will be considered incomplete and cannot be processed for approval until the information is received.

Personal health insurance is strongly advised, given that medical benefits are not covered under the student and instructor program. I understand that Providence St. Mary Medical Center may need to rely on the medical information I have provided on this form to provide assistance to me in the event of a health emergency, or during any other occasion (including illness or injury in which I may need immediate medical care.)
Therefore I certify that the information provided herein is true and correct to the best of my knowledge, and I agree to update this information in the event that my medical condition changes.

In being given permission to do my job shadow observation at Providence St. Mary Medical Center, I agree to:

1. Notify Education Services prior to my assigned shadow experience if I have any cold or flu like symptoms including but not limited to cough, runny nose, fever, sore throat, and gastrointestinal issues.
2. Follow the policies, procedures and the directions of the manager/director/provider.
3. Remain in the area where I am assigned.
4. Return my PSMMC name badge to Education Services at the end of my last observation.
5. Promise to keep CONFIDENTIAL all that I see and hear while observing at PSMMC.

Signature:_____ **Date:**_____

Confidentiality and Nondisclosure Statement

Name:_____ Position: Job Shadow/Observation Participant

I understand that in my involvement with the facility I may have access to information not generally available or known to the public. I understand that such information is confidential and belongs to the facility. Confidential data/ information includes but is not limited to patient, customer, member, provider, group, physician, student, resident, financial, and proprietary information, whether oral or recorded, in any form or medium. Confidential data/information also includes workforce member information that a workforce member does not wish to share. However, nothing in this statement restricts a workforce member's right to disclose wages, hours, and working conditions in accordance with federal and state laws. I understand that information developed by me, alone or with others, may also be considered confidential data/information belonging to the organization in accordance with our policies and procedures.

I will hold any confidential data/information I see or hear in strict confidence and will not disclose or use it except as authorized by the facility.

I will only access the confidential data/information that I need to do my job and will only provide such information to those who need it.

I understand that unless it is a part of my job function, I cannot remove any confidential data/information from the organization without authorization from my core leader and that I must return any such confidential data/information at the end of my employment, engagement or relationship with the facility. I understand that confidential data/information must be stored securely at all times as defined in our policy.

I understand it is my responsibility to become familiar with and abide by applicable laws, regulations, and our policies and protocols regarding the confidentiality and security of confidential data/information.

I understand that email is not a secure, confidential method of communication. I will never send confidential data/information to a personal email account or store it on my personally owned computer or mobile device. When sending messages that include confidential data/information to a non-facility email address as part of my job functions, I must type "#secure#" in the subject line to encrypt the contents of the email. I understand that texting and other messaging are not secure methods to transmit confidential data/information and agree not to use these types of communication methods to transmit such information. I agree to the acceptable use of computer equipment and resources as outlined in policy.

I understand that electronic communication technologies (Internet and email) are intended for job-related activities: however, limited personal use is permitted. Personal use is determined as incidental and occasional use of electronic communications technologies for personal activities that should normally be conducted during personal time, such as break periods, or before and after scheduled working hours, and is not in conflict with business requirements of the department. Internet usage is monitored and audited on a regular basis by our organization. The organization also reserves the right to monitor email and telephone usage.

I understand that this Confidentiality and Nondisclosure Statement does not limit my right to use my own general knowledge and experience, whether or not gained while employed by the facility or partner organization, or my right to use information that becomes generally known to the public through no fault of my own.

I understand that if I breach the terms of this Confidentiality and Nondisclosure Statement or for serious violations of policies related to use or disclosure of confidential data/information including but not limited to viewing of PHI (including demographic information alone) by use of identity look up modules in the electronic health record or by use of other means, for the purpose or personal benefit/curiosity or when there is no business or medical purpose, the facility may institute corrective action up to and including termination of my employment, engagement or relationship with the facility or partner organization.

Signature:_____ Date: _____

Updated 4/2021

PROVIDENCE St. Mary Medical Center

Disclosure Statement

Providence St. Mary Medical Center and Providence Medical Group has a long standing commitment to the safety and security of our patients, employees and clients. The Washington State Legislature helped us to further insure security of children, vulnerable adults, and developmentally disabled persons being served by Providence St. Mary Medical Center or Providence Medical Group by requiring us to conduct background checks on any prospective employee, volunteer, independent contractor, intern, resident, or medical staff who will or may have direct contact with or unsupervised access to children, vulnerable adults, or developmentally disabled persons during the course of his or her employment or affiliation with our organization. The federal government also requires Office of Inspector General excluded individual/entity database checks on all individuals employed by or associated with any business that participates in federally funded health care programs such as Medicare or Medicaid.

YOUR EMPLOYMENT OR AFFILIATION IS CONDITIONAL UPON THE RECEIPT OF A SATISFACTORY BACKGROUND REPORT AS DETERMINED BY PROVIDENCE ST. MARY MEDICAL CENTER AND PROVIDENCE MEDICAL GROUP. YOUR CONTINUED EMPLOYMENT OR AFFILIATION IS CONDITIONED UPON NOT COMMITTING ANY SUBSEQUENT PROHIBITED ACTS. WE RESERVE THE RIGHT TO CONDUCT ADDITIONAL BACKGROUND CHECKS AT ANY TIME DURING YOUR EMPLOYMENT OR AFFILIATION.

Please fully complete the following questions. This information will be maintained in accordance with applicable state and federal laws.

1. Have you ever been convicted of any of the following crimes against children or other persons, or crimes related to drugs?

YES	NO		YES	NO	
❒	❒	aggravated murder	❒	❒	endangerment with a controlled substance
❒	❒	first or second degree murder	❒	❒	child abuse or neglect as defined in RCW26.44.02
❒	❒	first or second degree kidnapping	❒	❒	first or second degree custodial interference
❒	❒	first, second or third degree assault	❒	❒	first or second degree custodial sexual misconduct
❒	❒	first, second or third degree assault of a child	❒	❒	malicious harassment
❒	❒	first, second or third degree rape	❒	❒	first, second or third degree child molestation
❒	❒	first, second or third degree rape of a child	❒	❒	first, second degree sexual misconduct with a minor
❒	❒	first or second degree robbery	❒	❒	patronizing a juvenile prostitute
❒	❒	first degree arson	❒	❒	child abandonment
❒	❒	first degree burglary	❒	❒	promoting pornography
❒	❒	first or second degree manslaughter	❒	❒	selling or distributing erotic material to a minor
❒	❒	first or second degree extortion	❒	❒	custodial assault
❒	❒	indecent liberties	❒	❒	violation of child abuse restraining order
❒	❒	incest	❒	❒	child buying or selling
❒	❒	vehicular homicide	❒	❒	prostitution
❒	❒	first degree promoting prostitution	❒	❒	felony indecent exposure
❒	❒	communication with a minor	❒	❒	criminal abandonment
❒	❒	unlawful imprisonment	❒	❒	manufacturing a controlled substance
❒	❒	simple or fourth degree assault	❒	❒	delivery of a controlled substance
❒	❒	sexual exploitation of minors	❒	❒	possession of a controlled substance with intent to, manufacture or deliver
❒	❒	first or second degree criminal mistreatment	❒	❒	any of these crimes as they may have been referred to in the past, renamed in the future, or labeled in another state

If your answer is "yes" to any of the above, please describe and provide the date(s) of the conviction(s) and the sentence(s) imposed:_____

_____

_____

2. ❒ Yes ❒ No Have you ever been convicted of any crime relating to obstruction of an investigation, fraud, theft, embezzlement, breach of fiduciary responsibility , or other financial misconduct?

If your answer is "yes", please describe and provide the date(s) of the conviction(s) and the sentence(s) imposed:_____

_____

_____

Per RCW 43.43.830, a vulnerable adult is defined as an adult: (a) of any age who lacks the functional, mental, or physical ability to care for themselves: or (b) found incapacitated under chapter 11.88 RCW; or (c) who has developmental disability as defined under RCW 71A.10.020; or (d) admitted to any facility as defined under RCW 74.34.020; or (e) receiving services from an individual provider as defined under RCW 74.34.020; or (f) receiving services from home health, hospice, or home care agencies licensed or required to be licensed under chapter 70.127RCW.

3. Have you ever been convicted of any of the following crimes relating to financial exploitation if the victim was a vulnerable adult:

❒Yes ❒ No first, second or third degree extortion

❒Yes ❒ No first, second or third degree theft

❒Yes ❒ No first or second degree robbery

❒Yes ❒ No forgery

❒Yes ❒ No any of these crimes as they may have been referred to in the past, renamed in the future or labeled in another state

I your answer is "yes" please describe and provide the date(s) of the conviction(s) and sentence(s) imposed:_____

_____

4. ❒Yes ❒No Have you ever been found in any dependency action to have sexually assaulted or exploited any minor or to have physically abused any minor.

5. ❒Yes ❒ No Have you ever been found by a court in a domestic relations proceeding to have sexually abused or exploited any minor or to have physically abused any minor.

6. ❒Yes ❒ No Have you ever been found in any disciplinary board final decision to have sexually or physically abused or exploited any minor or developmentally disabled person or to have abused or financially exploited any vulnerable adult?

7. ❒Yes ❒ No Have you ever been found by a court in a protection proceeding under chapter 74.34 RCW, to have abused or financially exploited any vulnerable adult?

If your answer is "yes" to any question 4 through 7 above, please describe and provide the date(s) of the finding(s) and the penalties imposed:_____

_____

8. ❒Yes ❒ No If you are applying for a licensed position, have you ever had your licensed revoked, suspended, surrendered, or lost the right to renew your license for reasons bearing on your professional competence, performance or financial integrity?

9. ❒Yes ❒ No Have you ever been excluded or suspended from participation in any federal or state health care program?

If your answer is "yes" to question 8 and/or 9 above, please explain in detail:_____

_____

10. ❒Yes ❒ No Have you ever had findings made against you in any civil adjudicative proceeding?

If your answer is "yes" to question 10 above, please explain in detail: _____

_____

11. ❒Yes ❒ No Have you ever been convicted of a crime not previously mentioned in this document?

If your answer is "yes" to question 11 above, please explain in detail: _____

_____

We may request your fingerprints to obtain from the Washington State Patrol criminal identification system a report of your record of criminal convictions for offenses against persons, civil adjudications of child abuse, and disciplinary board final decisions. The State Patrol's response will be sent directly to Providence St. Mary Medical Center. In addition, we will perform an excluded individual/entity database check with the Office of Inspector General.

You will be notified of the State Patrol's response within ten days after we receive the report. We will make a copy of the report available to you upon your request.

UNDER PENALTY OF PERJURY, I certify that the information on this form is true, correct, complete, and not misleading. I understand that if I am approved for employment or affiliation or at any time during my affiliation or involvement with Providence St. Mary Medical Center or Providence Medical Group that I complete this form, I can be discharged for any misrepresentation, omission, or misleading statement made in this Disclosure Statement. I understand that if I am approved for affiliation, my affiliation is conditioned upon receipt by Providence St. Mary Medical Center of a satisfactory report, as determined by Providence St. Mary Medical Center, from the Washington State Patrol and Office of Inspector General, and that continued affiliation will be conditioned upon satisfactory report(s) should further reports be deemed necessary by Providence St. Mary Medical Center. I understand and agree that it is my obligation to immediately inform us if a criminal conviction, civil adjudication, or disciplinary board final decision for any offenses listed on this form is issued against me or if I am excluded or suspended from participation in any federal or state health care program at any time during the course of my employment or affiliation with Providence St. Mary Medical Center or Providence Medical Group. Failure to notify Providence St. Mary Medical Center or Providence Medical Group will be grounds for immediate discharge.

_____ _____

Signature Date

_____ _____

Exact Legal Name, Printed Maiden Name/Other Names Used Date of Birth

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Return all the following *signed* forms to Providence St. Mary Medical Center Education Services Office:

All Participants:

1. Observation Application – This document

All experiences 2 or more days

1. Copy of Driver's License (current)
2. Copy of Health Insurance card (if possible)
3. Copy of Tuberculosis (TB) testing results
4. Copy of Immunization Record, including Flu and COVID
5. Orientation Completion Record