

Job Shadow / Observer Checklist

Throughout the completion of this checklist, you will be compiling items and documents that will become your **Job Shadow Packet**. When the items on this checklist are complete, you will be responsible for submitting your **Job Shadow Packet** to the UPMCSUSstudents (Service Account) UPMCSUSstudents@upmc.edu. You will not be permitted to observe with UPMC in North Central Pa. until your completed **Job Shadow Packet** has been submitted. Submit the **completed** forms and requirements of this checklist to the UPMC Student Service Account **one week** prior to your start date. As a reminder, you must be at least **18 years** of age to complete a job shadow, be a part of an academic partnership and are only permitted to shadow **40 hours or less**.

| Step | Task | Date Completed |
|------|--|----------------|
| 1. | Initiate a discussion with the desired department within the UPMC North Central Pa. Region. Provide the department with your name, email address, and anticipated start date. | |
| 2. | Complete the following: <ul style="list-style-type: none"> • Observer Track Sheet • Observer HIPAA / Infection Control Education Documentation sheet • UPMC Student / Visitor Confidentiality Agreement | |
| 3. | Submit the following to UPMC EmployeeHealth : <ul style="list-style-type: none"> • Submit your vaccination record to Paula Shimmel, LPN, at Shimmelpr@WorkPartners.com or fax all medical information to the My Health at Work office to the attention of Paula Shimmel at 570.321.1747. • All health information must be submitted 2 weeks prior to the start of your Job Shadow. | |

OBSERVER TRACK SHEET

Name _____ **PHONE NUMBER** _____

SCHOOL _____ **DATE OF BIRTH** _____

EMAIL _____

REQUESTED DEPARTMENT _____

ANTICIPATED DATE OF OBSERVATION _____

Observer HIPAA/Infection Control Education Documentation

Student: _____ Hospital Campus: _____ Date: _____
School: _____ Year: _____

The Mentor will explain or define the following information to the Observer:

- HIPAA – Health Insurance Portability and Accountability Act of 1996
- Protected Health Information (PHI) – patient name, address, birth date, SS#, insurance date, billing codes, diagnosis information, patient chart notes, and treatment regimens, drug information, etc
- Patient Confidentially all UPMC Susquehanna patient information that is seen, heard or written is confidential and should never be shared with any other person who does not have a job related need to know.
- Patient rights as outlined in the Notice of Privacy Practice pamphlet
- The penalties/consequences associated with confidentiality breached and/or violations of Federal or PA state HIPAA laws. Any observer who violates the HIPAA laws will not be permitted to return to or complete their assignment at UPMC Susquehanna.

The Mentor will explain or define the following information to the Observer:

- The Exposure Control Bloodborne Pathogen plan as it relates to the observer
- The use of personal protective equipment as it relates to the observer
- Hand hygiene practice requirement for the observer
- Isolation precaution requirement as it relates to the observer

By signing below, you acknowledge the responsibility relation to patient confidentiality and infection prevention and control practices and agree to abide by all HIPAA and other guidelines.

Observer's Signature

Date

UPMC Student/Visitor Confidentiality Agreement

UPMC considers that all staff information, business information, financial information and patient identifiable health information is confidential (and referred to in this agreement as “Confidential Information”). Both federal and state law also requires UPMC to keep patient identifiable health information confidential (including mental health, HIV, and drug and alcohol related treatment information).

By my signature below I agree that:

1. I will safeguard Confidential Information from access, disclosure, loss, tampering, or use by unauthorized person.
2. If I have been granted access to computer systems, I will use those computer systems only to access information related to the educational program(s) in which I am enrolled. For clinical computer systems, this includes only accessing information for patients who I have been assigned or for approved educational purposes. I understand that UPMC maintains an audit trail of my access to all patient identifiable health information and this audit trail may be reviewed at any time.
3. I agree that I will not access patient records (either in paper or electronic form) except when specifically permitted to do so by my preceptor. I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), my preceptor can only provide me with access to information which is necessary for the purposes of my student experience. No original or copies of any documents containing confidential information may be obtained or kept by me.
4. Any communications (including both oral and written communications) should be limited to purposes related to my educational activities. Any discussion must be in a manner that minimizes the chance that others can hear such conversation. Additionally, I will avoid discussions involving Confidential Information in elevators, hallways, buses, lunchrooms and other areas where unauthorized individuals may overhear me.
5. I will only discard Confidential Information as directed and in a manner approved by the facility where I am performing educational activities.
6. The use of the information for research purposes must be approved in advance by the Institutional Review Board (IRB) sanctioned by the UPMC entity where the research is to be performed.
7. Confidential Information should only be conveyed to individuals who have a need to know such information. Additionally, I will not convey Confidential Information outside the organization, such as to family or associates, or even to other UPMC staff members.
8. It is my responsibility to be familiar with and abide by all applicable UPMC Policies and Procedures.

[SIGNATURE PAGE TO FOLLOW]

I understand the violation of this agreement will result in corrective action up to and including removal from participation in the educational program in which I am enrolled and I may be permanently removed from UPMC premises and subject to criminal and civil liability.

Print Name

Signature

Date