

We are pleased that you are interested in participating in the UPMC Shadow Program. The mission statement of UPMC demonstrates our commitment to health care, teaching, and research. The Shadow Program assists you in exploring a career as an advanced practice provider. The purpose of this Shadow Program is to broaden your understanding of a career by observing an experienced, competent mentor while he or she performs job duties and responsibilities within the work environment.

Shadowing participants are required to pay \$50 per shadow experience (with one preceptor for 1-3 days, no more than 8 hours per day) via our APP Shadow Program Payment Portal which is accessible [here](#).

You are required to review our terms and conditions which is accessible on our webpage [here](#).

Current UPMC employees will have the fee waived, but it is still necessary to fill out the required information.

Before participating in the Shadow Program, you will also be required to submit the following documentation **60 days prior to your requested shadow date**:

1. Signed Job Shadowing Agreement
2. Signed Job Shadowing Application
3. Signed Parental Consent Form (if you are less than 18 years old)
4. Signed Release of Liability Statement (if you are less than 18 years old)
5. Signed Intent to Participate Form (if you are 18 years old or older)
6. Signed Health Insurance Portability and Accountability Act (HIPAA) Form
7. Signed Visitor Confidentiality Agreement
8. Completed Job Shadow Health Questionnaire
9. Medical documentation confirming tuberculin (TB) testing within the past 12 months
10. Flu Vaccine Documentation (If Shadowing September- March)
11. Signed and dated final page of the UPP Handbook (separate document)
12. High School seniors must submit a letter of intent from their guidance counselor that indicates that they have applied to/or are interested in applying to an advanced practice provider program.

Please note, we do not accept electronic signatures.

If you cannot produce medical documentation that indicates that you have been tested for tuberculosis (TB) within the past 12 months, then you will need to obtain a TB test. You can obtain this test from your school's student health department, your primary care physician, or the Immunization Clinic at the Allegheny County Health Department (ACHD). You can reach the ACHD at (412) 578-8060. (A nurse or physician will need to read the results of your TB test in person within 48 to 72 hours after the test).

Your responsibilities throughout this unique shadow experience include the following:

- To submit all required documentation (as listed above) to the Office of Advanced Practice Providers before participating in the Shadow Program;
- To observe the mentor performing his or her daily job duties and responsibilities;

- To engage in activities, such as taking notes and asking questions to expand your knowledge of the observed profession;
- To remain with the mentor at all times while in work areas; and
- To avoid any interference with the mentor's ability to perform his or her work.

Please forward the above required documentation by email to appstudents@upmc.edu.

Provided that a shadow opportunity exists within the hospital or practice that meets your career interests, we will assist with coordinating this experience for you. We will contact you to further discuss details after you have submitted all of the above required documentation.

We are excited to provide this valuable, rewarding experience to you! If you have any questions regarding the Shadow Program, please contact us at 412-864-2753.

Enclosures: UPMC Job Shadowing Agreement
UPMC Job Shadowing Application
Parental Consent Form (if you are less than 18 years old)
Release of Liability Statement (if you are less than 18 years old)
Intent to Participate Form (if you are 18 years old or older)
Health Insurance Portability and Accountability Act (HIPAA) Form
Visitor Confidentiality Agreement
Job Shadow Health Questionnaire

UPMC Job Shadow Program

Overview:

The Job Shadow Program at UPMC provides learning opportunities designed to help you explore a career as an advanced practice provider. The program offers you the chance to learn more about health care career options and the skills that different occupations require. Through it all, you will gain a better understanding of the connection between school, work, and your professional goals.

A typical job shadow experience lasts one day for four hours. Through the Job Shadow Program, you have the opportunity to experience the workplace setting and observe the duties that an advanced practice provider performs. During the Job Shadow, workplace observations and mentor interactions are strongly encouraged; however, patient contact is not permitted.

Eligibility Criteria:

In order to participate in the UPMC Job Shadow Program, you must be at least a high school senior and interested in exploring a career as an advanced practice provider.

Appropriate attire during the shadow experience normally is business casual (e.g., no jeans, shorts, T-shirts with logos, or revealing tops). Clean, presentable tennis shoes or any other comfortable closed-toed shoes are recommended. However, the UPMC facility that is providing the shadow experience does reserve the right to impose a different dress code as appropriate during the shadow experience.

All requests must be submitted by partnering organizations or high school administrator.

Program Goals:

The goals of the Job Shadow program at UPMC are to empower you to:

- Identify and observe the daily routines of an advanced practice provider
- Gain awareness of the academic background, and technical/interpersonal skills required in healthcare professions
- Build an understanding of the cultures and work environments in which health careers occur
- Develop an understanding of the critical connections between school, work, and professional goals.
- Gain a realistic experience in the work day of their career choice

Process:

- Contact your school administrator or community organization to schedule a job shadow opportunity.
- Copy and complete all required forms highlighted below, including PSD orientation packet, prior to beginning your shadow experience.
- Submit your completed application for review. UPMC will contact you regarding the status of your application and notify you of any additional requirements that must be met before the start of the experience.
- The job shadow date will be reserved after all required paperwork is received.

Due to the number of requests received and the length of time to prepare your experience, **a minimum of 60 days is required to complete arrangements.** Every effort will be made to schedule your experience in a timely manner.

Job Shadow Program Orientation Guide

General Information

- You will be required to sign a confidentiality statement.
- A name tag/identification badge must be worn or in your possession at all times.
- You will be instructed where to park.
- Smoking is prohibited in UPMC owned or leased facilities, buildings, passageways, and parking garages.
- Cell phones must be turned off during shadow and can only be used in designated areas.
- Photo taking is not permitted at any time.
- You will be accompanied by a staff member at all times.
- Shadow is observation only. You are not permitted to assist in any way.
- Patient's consent is required for observations. Patients have a right to decline. If this occurs, you will be asked to step out of the area.
- Patient safety comes first. Your shadow host will determine which activities are appropriate for observation.
- If you have an active infection on the day that you are scheduled for a job shadow, such as a cold, flu, conjunctivitis, or chicken pox, please reschedule.

If you have any concerns or issues while you are in our hospital or other UPMC facility, please discuss them with your department host.

I would like to participate in a Job Shadow Experience at a UPMC facility.

I understand that job shadowing is an observation experience only, and that no work is to be performed. At the start of my job shadowing, I will be assigned to an advanced practice provider who will lead me through a department in a hospital or physician's office. They will discuss a typical workday, explore different aspects of working in a healthcare setting, and identify the skills that are needed in the working world. While on the UPMC premises, I will abide by all policies, rules and regulations of UPMC and follow the direction of the advanced practice provider to whom I am assigned.

Liability Release

I release UPMC, its employees and volunteer staff from any claim or liability arising from my participation in the job shadowing program. I understand that I must provide my own transportation to/from the UPMC location.

Photo Release

I understand that there is a possibility that job shadow students may be photographed during their experience to help promote the program. I grant permission to be photographed for this purpose.

Authorization for Medical Treatment

I hereby authorize UPMC to provide emergency or urgent medical treatment as deemed advisable by any physician or surgeon on the professional staff of UPMC. UPMC will not be responsible for the costs of such medical treatment. I understand that this authorization is given in advance of any specific diagnosis, treatment or hospital care required, and that UPMC will rely on this authorization only in the event of any emergency or urgent situation. In the case of a minor student, every effort will be made to contact the parent/guardian listed prior to treatment, and the consent will only be used at a time when the parent/guardian consent may not be available.

Customer Service, Inclusion and Respect

UPMC has a mission of ensuring that inclusion is at the core of what we do every day. Inclusion begins with a core belief that everyone deserves dignity and respect. It is the policy of UPMC to promote an environment free from verbal or physical violence and harassment in the workplace or anywhere on the hospital campus, and to provide access to Public Safety and immediate assistance in the event of an incident involving potential harm to patients, visitors and employees.

Culture Awareness – Understanding and respecting patients' cultural values, beliefs and practices are important. A patient's ethnic or religious affiliation may affect how they view health care.

Confidentiality of Patient Information

Patients have the right that their information is kept confidential. As such, UPMC considers that all patient information is confidential. Additionally, both federal and state law requires UPMC to keep patient information confidential (including mental health, HIV, and drug and alcohol related treatment information).

Patient information includes such things as:

- The patient's name and other general information about the patient;
- The patient's diagnosis and other medical conditions that the patient may have;
- Treatments, tests and medications that the patient receives; and
- Information in the patient's medical record, contained in UPMC's computer systems or other information that might be posted in the patient's room;

As part of the job shadowing program, I understand that I will be in a facility where patients are being treated. Additionally, as a part of the job shadowing program, I may take tours and/or be provided with demonstrations. I understand that through the course of the job shadowing program, tours or demonstrations, I may come into contact with patient information. I understand that UPMC is obligated under both federal and state law to keep patient information confidential. I further understand that if I encounter patient information through the course of the job shadowing program, tours or demonstrations, it is solely for the purpose of demonstrating concepts of principles, and not for the purpose of disclosing the patient's information, condition, diagnosis or treatment.

I agree that I will not attempt to view any patient information. I also agree that I will not copy or otherwise remove any patient information from the facility. Additionally, I agree that I will not disclose to others any patient information that I may come into contact with.

Removal from the Job Shadowing Program

I understand that UPMC may remove me from the job shadowing program for any reason, or no reason at all. This includes, but is not limited to:

- My failure to abide by the terms of this agreement or UPMC policies;
- My failure to act in a responsible and mature manner; or
- If UPMC believes it is in my best interest, or the best interests of its patients or staff.



Job Shadowing Agreement

By signing below, I agree to the terms of this agreement and verify that I am at least a senior in high school.

Signature of Job Shadowing participant: _____

Printed Name: _____ Date: _____

Signature of Parent/Guardian (required for students under that age of 18): _____

Printed Name: _____ Date: _____

Telephone (work) _____ (cell phone or home) _____

Parental Consent Form

(To be completed if participant is less than 18 years old)

I, (Mr., Mrs., Ms.) _____, the legal guardian of _____, give my consent for him/her to participate in all activities associated with the UPMC PSD Shadow Program.

The purpose of this Shadow Program is to broaden an individual's understanding of a particular career by observing an experienced, competent mentor while he or she performs jobs duties and responsibilities within the work environment. In general, the shadow experience will last for three or less days.

I understand that in order to participate in the Shadow Program, my child will need to provide medical documentation confirming tuberculosis (TB) testing within the past twelve (12) months and a signed Confidentiality Agreement. My child will comply with all rules and regulations of the hospital while in this program. We understand that failure to comply with the hospital's rules will result in immediate removal from the Shadow Program.

I hereby release and discharge UPMC, its agents, servants, and employees, and persons, firms or corporations contracting with, or acting on behalf, of these groups, with respect to the activities of the Shadow Program as well as their heirs, executors, administrators, successors, or assigns, from any cause of action of any nature whatsoever arising from my child's participation in the activities of the Shadow Program.

Legal Guardian (sign)

Date

Shadow Program Participant (sign)

Date

RELEASE OF LIABILITY - Please read carefully before signing.

SIGNATURE OF PARENT/GUARDIAN is **REQUIRED** if participant is **less than 18 years old**.

This is a legally binding Release made by, _____ and _____
(Print full name of parent) (Print full name of parent)

to UPMC Health System, any other controlled or owned subsidiary of UPMC Health System, their directors, officers, employees, agents and contractors. (Collectively, the Released Parties).

I/We recognize and understand that my/our child _____ desires to
(Print full name of child)

participate in a Job Shadow Day which will consist of one or more of the following activities: providing an opportunity for a student(s) to "shadow" an employee and participate in workplace activities at our facility; provide an opportunity for a small group of students to tour our facility; and/or speak to a group of students about UPMC employment positions within the organization. I/We understand that UPMC Health System and any other Released Parties do not require my/our child to participate in these activities. However, we are willing to have my/our child participate despite the possible dangers and risks as set forth herein.

I/We fully recognize that there are dangers and risks to which my/our child may be exposed by participating in any or all of these activities, either directly by way of my/our child's own actions or by the actions of others, including but not limited to injuries or conditions such as lacerations, abrasions, contusions and fractures, dental damage, brain injuries, as well as other injuries up to and including loss of life. I/We authorize our child's participation in the activities with full appreciation of the adherent risks and the release of liability provided herein.

I/We agree to assume all of the risks and responsibilities in any way associated with these activities. In consideration of and return for the services provided to me/us by UPMC Health System and the Released Parties, I/we hereby release each and all of the them from any and all liability, claims and actions that may arise from injury or harm to my/our child or from damage to his/her property, in connection with these activities. I/We understand that this release covers liability, claims and actions caused entirely or in part by any acts or failures to act of UPMC Health System or any of the Released Parties, including but not limited to negligence, mistake or failure to supervise by UPMC Health System, or any other Released Parties.

I/We understand that this Release means I/we am/are giving up, among other things, the right to sue UPMC Health System, or any other Released Party for injuries, damages or losses my child or I/we may incur. I/We also understand that this Release binds my/our heirs, executors, administrators and assigns, as well as myself/ourselves. Further, I/we agree to defend, indemnify and hold harmless UPMC Health System, and any other Released Parties from and against any claim, damage, liability, injury expense or loss, including but not limited to reasonable attorney fees, by reason of any suit, claim, demand, judgement or cause of action initiated by or on behalf of _____
(Child's name)

arising out of or in connection with _____'s participation in these activities. I/We
(Child's name)

further represent that to the best of my/our knowledge, information and belief, my/our child is physically able to participate in the above-described activities, without any undue or unusual risk to him/her or to others.

I/We have read this entire Release. I/We fully understand it and I/we intend to be legally bound by it.

Releasor's Signature

Releasor's Signature

Date

Intent to Participate Form

(To be completed if participant is 18 years old or older)

I, _____, request to participate in all activities associated with the UPMC PSD Shadow Program. The purpose of this Shadow Program is to broaden my understanding of a particular career by observing an experienced, competent mentor while he or she performs jobs duties and responsibilities within the work environment. In general, the shadow experience will last for three or less days.

I understand that in order to participate in the Shadow Program, I will need to provide medical documentation confirming tuberculosis (TB) testing within the past twelve (12) months and a signed Confidentiality Agreement. I will comply with all rules and regulations of the Hospital while in this program. I understand that failure to comply with the Hospital's rules will result in immediate removal from the Shadow Program.

I hereby release and discharge UPMC, its agents, servants, and employees, and persons, firms or corporations contracting with, or acting on behalf, of these groups, with respect to the activities of the Shadow Program as well as their heirs, executors, administrators, successors, or assigns, from any cause of action of any nature whatsoever arising from my participation in the activities of the Shadow Program.

Shadow Program Participant (sign)

Date

HIPAA COMPLIANCE

PROTECTING PATIENT PRIVACY: EVERYONE’S RESPONSIBILITY

What is HIPAA? The Health Insurance Portability & Accountability Act of 1996 and the regulations which were enacted by the US Department of Health and Human services to implement the Act, provide new rules for how hospitals and other health-care providers, such as UPMC, are permitted to use and disclose or release patient information.

Who is affected? All healthcare organizations and providers, such as UPMC, our medical staff and any member of UPMC’s “workforce.”

Are there penalties? HIPAA calls for severe civil and criminal penalties for noncompliance, including fines up to \$25,000 for multiple violations of the same standard in a calendar year; fines up to \$250,000; and/or imprisonment up to 10 years for knowing misuse of identifiable patient information.

Privacy and Confidentiality: In general, privacy refers to a patient’s right to access his/her health information. The rule covers all individually identifiable health information that health care organizations and providers, such as UPMC, possess.

The Privacy standards:

- limit the use and release of private health information without patient/parent consent;
- give patients new rights to access their medical records and to know who else has accessed them;
- restrict most disclosure of health information to the minimum needed for the intended purpose;
- establish new criminal and civil sanctions for improper use or disclosure; and
- establish new requirements for access to records by researchers and others.

Implementing HIPAA : It is the policy of UPMC to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule pertaining to the use and disclosure of Protected Health Information (PHI). A number of policies have been developed to assist in our compliance efforts. A student’s access to a patient’s medical record shall only be with the written authorization of his/her UPMC Sponsor.

Questions? If you have any questions about how patient information should be used or shared with others outside of the UPMC Health System, you should contact the Corporate Compliance and Privacy Officer at (412) 692-7842.

Non-Compliance: Your failure to abide by the HIPAA regulations and UPMC policies concerning patient information may result in your immediate dismissal from the Shadow Program, as well as all other penalties described above.

Program Participant (sign)

Date

VISITOR CONFIDENTIALITY AGREEMENT

Visitor Name: _____ Visit Date: _____
(Print Name)

Visit Location and Purpose: _____

I understand that I will be taking a tour and/or be provided with a demonstration at the UPMC facility mentioned above. I understand that through the course of this tour or demonstration, I may come into contact with patient information. I understand that this information is confidential information for which UPMC is obligated under both federal and state law to keep confidential. I further understand that if I encounter patient information through the course of my tour or demonstration, it is solely for the purpose of demonstrating concepts or principals, and not for the purpose of disclosing the patient's information, condition, diagnosis or treatment.

I agree that I will otherwise not attempt to view any patient information. I also agree that I will not copy, or otherwise remove any patient information from the facility. Additionally, I agree that I will not disclose any patient information that I may come into contact with.

Signed: _____ Date: _____

JOB SHADOW HEALTH QUESTIONNAIRE

For Signs and Symptoms of Potential Communicable Diseases

Name: _____

If under 18, please have parent or guardian fill out the chart below.

Please complete each question below:	Yes	No	Unsure
1. Do you have a persistent cough? (i.e., a cough lasting longer than three weeks?)			
2. Do you have night sweats?			
3. Have you had significant weight loss (10 lbs.) in the last three weeks?			
4. Have you had unexplained fever in the last three weeks?			
5. Do you have a lack of appetite?			
6. Are you coughing up bloody sputum?			
7. Have you had contact with someone that has Tuberculosis?			
8. Have you had a positive mantoux tuberculosis skin test in the past?			
9. Do you have diarrhea?			
10. Do you have a skin rash?			
11. Do you have any eye drainage?			
12. Have you had chicken pox?			
13. Have you had measles?			
14. Have you had German measles (rubella)?			
15. Have you had mumps?			

Signed: _____ Date: _____

If under 18, please have parent or guardian fill out the following information:

Name: _____ Relationship: _____

Signed: _____ Date: _____