

JOB SHADOW APPLICATION

Date _____ Previous or current clinical rotation at Swedish Yes No
Current Swedish Employee Yes No

Name _____ Date of Birth _____
Last name First name M I

Address _____
City State Zip

Email Address _____

Home Phone _____ Cell Phone _____

Emergency Contact Name (PRINT) and Cell Phone # _____ Name of School and if you are a minor, Grade _____

Requested area/department and hospital for job shadow placement _____ Dates/Times available _____

Purpose for shadow _____

Have you been in contact with a Swedish staff member regarding job shadow placement? Yes No

Name _____ Department _____

**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 Swedish Medical Center.

I agree that (PRINT) _____ may participate in the Observational Job Shadow Program at Providence Swedish 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 Swedish 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 Swedish, 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 _____

Information Confidentiality Agreement

As a condition of and in consideration of my use, access, and/or disclosure of confidential information, I understand and agree to the confidentiality requirements outlined in this Agreement. I understand that these requirements and my responsibility to protect the confidentiality and security of information apply when I am working off-campus as well as at Swedish Medical Center (Swedish or SMC) including all owned and operated facilities and clinics.

Definitions

Confidential Information: Information which may include, but is not limited to:

- Patient information (medical records, conversations, demographic information, financial information)
- Employee information (salaries, employment & payroll records, unlisted phone numbers, health records)
- Swedish proprietary information (financial reports, production reports, report cards, reimbursement tables and contracted rates, strategic plans, internal reports, memos, contracts, peer review information, credit information, communications, computer programs, technology)
- Third party information (computer programs, vendor information, technology)

- 1) I will access, use and disclose minimum confidential information only as necessary to perform my job functions. This means, among other things, that:
 - a) I will only access, use, and disclose the minimum confidential information as authorized to do my job;
 - b) I will not in any way access, use, divulge, copy, release, sell, loan, review, alter, or destroy any confidential information except as properly and clearly authorized within the scope of my job and in accordance with all applicable Swedish policies and procedures and with all applicable laws;
 - c) I will report to my supervisor, manager or to the Swedish Privacy Officer any individual's or entity's activities that I suspect may compromise confidential information.

(Section 2 only applies if you have been granted electronic access to SMC systems, including email.)

- 2) Because all of my passwords (and/or other authentication devices such as tokens or cards) are the equivalent of my signature and because I am the only person authorized to use them, I agree to the following:
 - a) I will safeguard and not disclose my passwords or allow the use of my authentication devices by anyone including my manager or supervisor or another employee.
 - b) I will not request access to or use any other person's passwords or authentication devices.

- c) I accept responsibility to log out of the system to which I'm logged on. I will not under any circumstances leave unattended a computer to which I have logged on without first either locking it or logging off the workstation.
 - d) If I have reason to believe that the confidentiality of my password has been compromised, I will immediately change my password.
 - e) I understand that my password will be deactivated in the event that I am no longer employed by or in an education relationship with Swedish, have no medical staff privileges at Swedish, or when my job duties no longer require access to the computerized system.
 - f) I understand that Swedish has the right to conduct and maintain an audit trail of all access to patient information and other system activity such as Internet access and that Swedish may conduct a review to monitor appropriate use of my system activity at anytime and without notice.
 - g) I understand and accept that I have no individual rights to or ownership interests in any confidential information referred to in this agreement and that therefore Swedish may at any time revoke my passwords or access codes.
3. I understand that it is my responsibility to be aware of Swedish policies regarding electronic communications and other policies that specifically address the handling of confidential information and misconduct that warrants corrective disciplinary action.
4. I understand that in addition to protecting confidentiality, I am also required to be aware of the *Information Security: Acceptable Use of Information Assets* policy and to abide by all of its requirements regarding the appropriate use of Swedish computer systems.
5. I understand that any fraudulent application, violation of confidentiality or any violation of the above provisions may result in disciplinary action, including loss of system and information access privileges, as well as other appropriate disciplinary measure up to and including termination of employment and/or affiliation with Swedish.
6. I understand my obligations under this Agreement will continue indefinitely after leaving my employment or business relationship with Swedish.

My signature below indicates that I have read, accept, and agree to abide by all of the terms and conditions of this Agreement and agree to be bound by it.

Signature: _____ Date: _____

Printed Name: _____

Professional Discipline (e.g. nursing, PT, RT): _____

Instructor Name: _____ School Name: _____

PURSUANT TO THE REQUIREMENTS OF RCW 43.43.830, WE MUST ASK YOU TO COMPLETE THE FOLLOWING DISCLOSURE STATEMENT. THIS INFORMATION WILL BE KEPT CONFIDENTIAL.

Have you ever been convicted of any of the following crimes against persons?

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Aggravated Murder	<input type="checkbox"/>	<input type="checkbox"/>	Indecent Liberties
<input type="checkbox"/>	<input type="checkbox"/>	First or Second Degree Murder	<input type="checkbox"/>	<input type="checkbox"/>	Incest
<input type="checkbox"/>	<input type="checkbox"/>	First or Second Degree Kidnapping	<input type="checkbox"/>	<input type="checkbox"/>	Vehicular Homicide
<input type="checkbox"/>	<input type="checkbox"/>	First, Second, or Third Degree Assault	<input type="checkbox"/>	<input type="checkbox"/>	Unlawful Imprisonment
<input type="checkbox"/>	<input type="checkbox"/>	First, Second, or Third Degree Assault of a Child	<input type="checkbox"/>	<input type="checkbox"/>	Simple Assault
<input type="checkbox"/>	<input type="checkbox"/>	First, Second, or Third Degree Rape	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Exploitation of Minors
<input type="checkbox"/>	<input type="checkbox"/>	First, Second, or Third Degree Rape of a Child	<input type="checkbox"/>	<input type="checkbox"/>	First or Second Degree Custodial Sexual Misconduct
<input type="checkbox"/>	<input type="checkbox"/>	First or Second Degree Robbery	<input type="checkbox"/>	<input type="checkbox"/>	First or Second Degree custodial interference
<input type="checkbox"/>	<input type="checkbox"/>	First or Second Degree Manslaughter	<input type="checkbox"/>	<input type="checkbox"/>	Felony Indecent Exposure
<input type="checkbox"/>	<input type="checkbox"/>	First or Second of Third Degree Extortion	<input type="checkbox"/>	<input type="checkbox"/>	Criminal Abandonment
<input type="checkbox"/>	<input type="checkbox"/>	First or Second Degree Criminal Mistreatment	<input type="checkbox"/>	<input type="checkbox"/>	Malicious Harassment
<input type="checkbox"/>	<input type="checkbox"/>	Child Abuse or Neglect as defined in RCW 26.44.020	<input type="checkbox"/>	<input type="checkbox"/>	First, Second, or Third Degree Child Molestation
<input type="checkbox"/>	<input type="checkbox"/>	Selling or distributing erotic material to a minor	<input type="checkbox"/>	<input type="checkbox"/>	First or Second or Third Degree Sexual misconduct with a minor
<input type="checkbox"/>	<input type="checkbox"/>	Endangerment with a controlled substance	<input type="checkbox"/>	<input type="checkbox"/>	Patronizing a Juvenile Prostitute
<input type="checkbox"/>	<input type="checkbox"/>	Custodial Assault	<input type="checkbox"/>	<input type="checkbox"/>	Child abandonment
<input type="checkbox"/>	<input type="checkbox"/>	Child buying or selling	<input type="checkbox"/>	<input type="checkbox"/>	Promoting Pornography
<input type="checkbox"/>	<input type="checkbox"/>	First Degree promoting prostitution	<input type="checkbox"/>	<input type="checkbox"/>	Violation of Child Abuse Restraining Order
<input type="checkbox"/>	<input type="checkbox"/>	Communications with a minor	<input type="checkbox"/>	<input type="checkbox"/>	Prostitution
<input type="checkbox"/>	<input type="checkbox"/>	First Degree Arson	<input type="checkbox"/>	<input type="checkbox"/>	Or any of these crimes as they may have been renamed.
<input type="checkbox"/>	<input type="checkbox"/>	First or Second or Third Degree Theft	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	First Degree Burglary	<input type="checkbox"/>	<input type="checkbox"/>	

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.

Have you ever been convicted of any of the following crimes relating to financial exploitation of a person 60 years of age or older, who has functional, mental, or physical inability to care for himself or herself or is a patient in a state hospital?

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	First, Second, or Third Degree Extortion	<input type="checkbox"/>	<input type="checkbox"/>	Forgery
<input type="checkbox"/>	<input type="checkbox"/>	First or Second Degree Robbery	<input type="checkbox"/>	<input type="checkbox"/>	Or any of these crimes as they may have been renamed
<input type="checkbox"/>	<input type="checkbox"/>	First, Second or Third Degree Theft			

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.

If your record shows a conviction for the following crimes, you may be disqualified from participation:

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Possession with the intent to deliver a controlled substance	<input type="checkbox"/>	<input type="checkbox"/>	Possession with the intent to manufacture a controlled substance
<input type="checkbox"/>	<input type="checkbox"/>	Delivery of a Controlled Substance	<input type="checkbox"/>	<input type="checkbox"/>	Manufacture of a Controlled Substance

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.
