



# YORK GENERAL

*Our Focus is You.*

Welcome to York General! We are so excited that you are interested in shadowing in our organization. Please return completed forms and an up-to-date immunization record to [education@yorkgeneral.org](mailto:education@yorkgeneral.org). Your application and all required documentation should be submitted to the Education Coordinator at least 2 weeks in advance of your anticipated shadowing date(s). If requests are submitted without ample time for review and completion of requirements, we cannot guarantee that you will be able to shadow on your chosen date.

Once your forms have been approved, you will receive an email from Universal Background Screening with a link to complete a background check. Please respond promptly as the link is only valid for 24 hours. Upon background check clearance, you will be notified by the Education Coordinator that you are ready to be scheduled.

Any additional information necessary for participation in the York General Shadowing Program will be requested by the Education Coordinator. Please reach out with any questions or concerns to:

## **Education Coordinator**

York General Hospital

2222 N. Lincoln Avenue

York, NE 68467

Direct line: 402-362-0467

[education@yorkgeneral.org](mailto:education@yorkgeneral.org)

## Application

Last name: \_\_\_\_\_ First name: \_\_\_\_\_

Date of birth (mm/dd/yy): \_\_\_\_\_ Grade (if applicable): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip code: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Gender: \_\_\_\_\_

Are you a current employee of York General?  Yes  No

Are you interested in shadowing as part of a school program?  Yes  No

**If yes**, name of advisor: \_\_\_\_\_

Expected date to begin shadowing experience: \_\_\_\_\_

**If no**, expected date to shadow (list 3 in order of preference): \_\_\_\_\_

Do you require any reasonable accommodations due to a disability?  Yes  No

Do you have any severe allergies or medical conditions that affect your ability to observe in any particular area?  Yes  No

If yes, please explain: \_\_\_\_\_

In a few sentences, please explain why you are interested in shadowing at York General: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Proof of Immunizations: I will submit record of receiving the following immunizations prior to my shadowing experience being scheduled:

DPT/DTap/Tdap (Tetanus)

Influenza (required October through March)

Hepatitis B

MMR

Varicella (Chicken Pox)

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

## Acceptance of Basic Responsibilities Related to Health Insurance Portability and Accountability Act (HIPAA)

This form must be signed and returned to the Education Coordinator at York General as documentation that you have received HIPAA training and that you know and accept your basic responsibilities as a participant of the Shadowing Program at York General. This is a condition of your acceptance in the program.

As a participant in the York General Shadowing Program, I accept basic responsibility to:

1. Take patient privacy seriously.
2. Complete all required training.
3. Ask questions of the Program Coordinator when I am unsure of how HIPAA or York General policies apply to a situation.
4. Promptly report any first-hand knowledge that there has been a violation of HIPAA or improper use or disclosure of protected health information at York General.
5. Never access any information under another person's identity and always comply with York General's access controls.
6. Not retaliate against a patient or employee who files a complaint or exercises rights permitted by HIPAA or York General policies.
7. Promptly notify the Program Coordinator of a HIPAA-related complaint, in oral or written form, made by a patient or someone on behalf of a patient.
8. Cooperate in assessments or investigations by York General seeking information about compliance with HIPAA.
9. Never destroy HIPAA records unless authorized to do so; never destroy records involved in a complaint or investigation.
10. Never promise patients that their information will receive special protection and never agree to voluntary restrictions on how York General will use and disclose information.
11. Direct all patient questions about copies of their record to their assigned York General care staff person.
12. Both Nebraska and Federal law protect the confidentiality of Protected Health Information. I understand that this is a binding document and I will be personally liable for any unauthorized breach of information.

Print name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Guardian Signature (in addition, if under 19 years of age):

\_\_\_\_\_



## Confidentiality Statement

As a participant of the York General Shadowing Program, I understand that I may see information or overhear statements regarding patients, residents, physicians, clinical staff, or organizational members which may be considered confidential. I attest that I will not discuss, in any capacity, the contents of this confidential information outside of my direct purposes in the Shadowing Program. I also attest that I will not access any protected areas of York General where I am not directly authorized and escorted by a York General employee.

All patient and family information acquired at York General may only be shared with those directly involved or responsible for patient care. All information will be held to strict confidence and not released for any reason outside of York General. No reference is to be made regarding the identity, diagnosis, or treatment of a patient. All questions regarding this can be directed to the nurse or provider caring for the patient, or the Education Coordinator.

I understand that failure to maintain these guidelines will result in immediate removal from the program and further consequences therein.

Print name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Guardian Signature (in addition, if under 19 years of age):

\_\_\_\_\_

## Statement of Professionalism

As a condition of your participation in the York General Shadowing Program, please attest to adherence to the following guidelines for professionalism:

- Dress modestly, in scrubs or well-fitting business casual.
- No sleeveless or revealing clothing will be allowed.
- Wear comfortable closed-toed shoes.
- No extreme hair styles/colors or facial jewelry.
- No cursing.
- Speak in a respectful tone.
- No cell phone usage.
- Keep all valuables at home.
- Reply to all communications in a timely manner.
- Notify Education Coordinator in advance of any absence. I understand that I cannot participate in the program if I am ill. If I am ill on the day I'm scheduled to shadow, I will notify York General of my expected absence.

The York General Shadowing Program Coordinator will evaluate any violations of these guidelines and determine discretionary action up to and/or including removal from the program.

Print name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Guardian Signature (in addition, if under 19 years of age):  
\_\_\_\_\_

## Behavior Standards

As a participant of the York General Shadowing Program, I understand that I am a reflection of the entire organization and I pledge to uphold the Behavior Standards as outlined below.

### Attitude

- I will treat everyone, at all times, with dignity, respect, empathy, honesty, compassion, courtesy, and sincerity.
- I will come to work with a smile and an optimistic mind knowing my attitude is contagious.
- I will value and respect differences in backgrounds, culture, and experiences, recognizing the power and strength of our diverse organization.
- I will demonstrate a positive attitude, and will be both gracious and grateful, thanking those with whom I interact.
- I will have an open mind to new ideas and innovative ways of thinking to improve our organization.

### Teamwork

- I will make a conscious effort to work positively with everyone and seek opportunities to manage up my co-workers.
- I will achieve balance between presenting my own solutions to problems and accepting the ideas of others for the greater good of the organization and those we serve.
- I will build up my team as a member of this organization sharing in both successes and failures.
- I will maintain my focus on caring for our patients, residents, families, and all others we serve.

### Ownership

- I will take pride in my participation in the workplace and support those across the organization.
- I will take an active role in using resources effectively, efficiently, and responsibly.
- I will hold myself and others accountable for behavior and performance.
- I will make every effort to keep our organization safe and secure, whether environmental, behavioral, or clinical.

### Integrity

- I will be truthful, take responsibility for my actions, and consider my conscience when making decisions.
- I will respect all those we serve as individuals.
- I will adhere to the values and uphold the mission of the organization by giving my best effort every day.
- I will handle all confidential information appropriately.

### Appearance

- I will dress according to written policies, take pride in my appearance, and wear my name tag visibly at all times.
- I will keep my personal work area neat, organized, professional, and will return equipment to its proper place.
- I will do my part to maintain an appropriate cultural appearance that promotes an inviting, courteous, supportive, approachable, and respectful atmosphere throughout the organization.

### Communication

- I will communicate professionally and clearly at all times.
- I will listen attentively, be focused in all interactions, avoid distractions while communicating, and be willing to receive and provide honest feedback.
- I will prepare for, anticipate, and understand the needs of all those with whom I interact.
- I will respond appropriately, in a timely, friendly, and empathetic manner.
- I will convey compassion and respect in my non-verbal language, such as tone of voice, posture, and eye contact.

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Participant Name (Print)

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Participant Signature

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Date

## Release of Liability

I, \_\_\_\_\_, hereby acknowledge that I am fully and soundly aware of the inherent dangers that may be present with my participation in the York General Shadowing Program, which may include but is not limited to exposure to blood, bodily fluids, and contagious pathogens. I understand that my participation in this program may result in emotional or physical trauma or illness.

In consideration of my participation in this program, I hereby assume all risk associated with participation and in connection to any activities included in the York General Shadowing Program. I officially release York General and any of their associates, representatives, or affiliates of any and all liability in regard my participation in the York General Shadowing Program.

I attest that I am competent to sign this agreement, understanding that it is contractual, and choosing to do so as an act of free will. I have been fully informed of the risks associated with my participation in the York General Shadowing Program, and I have read this agreement in its entirety.

Print name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Guardian Signature (in addition, if under 19 years of age):

\_\_\_\_\_

## Intent of Interest

I, \_\_\_\_\_, am interested in participating in the York General Shadowing Program. The departments/professions I am most interested in shadowing are:

\_\_\_\_\_, \_\_\_\_\_.

I have reviewed the Student Shadowing Program Orientation PowerPoint. I will direct any questions to the Education Coordinator for clarification.

Print name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Guardian Signature (in addition, if under 19 years of age):

\_\_\_\_\_

Advisor Signature (if participating as part of a school program):

\_\_\_\_\_

York General Use Only:

The above-mentioned student is approved to participate in the York General Shadowing Program, contingent upon a satisfactory background check and compliance with program guidelines.

Department Director Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Department Director Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Department Director Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Education Coordinator Signature: \_\_\_\_\_ Date: \_\_\_\_\_