Ochsner Medical Center – New Orleans
Adult Job Shadow

Job Shadow Description:
At Ochsner Medical Center, we have a structured job shadowing program that allows individuals an opportunity to shadow a physician, advanced practice provider, or other healthcare professional for half days once a week for up to 3 weeks in a month time-frame. If you would like to have a more extended experience, we encourage you to apply for the volunteer program.

Any adult who currently desires to seek further insight into a particular department in order to gain personal understanding and general knowledge related to job function and environment is invited to apply for a job shadow experience. Participants must be at least 18 years of age to participate. A Job Shadow experience (up to 3 days) is available to individuals once a year.

Purpose:
Job shadowing is an educational experience option in which participants learn about a job by walking through the work day as a shadow to an employee. The job shadowing education experience is temporary, unpaid exposure to the workplace in an occupational area of interest to the participant. Participants witness firsthand the work environment, employability and occupational skills in practice, the value of professional training, and potential career options. Job shadowing is designed to increase career awareness, help model Participant behavior through examples, and reinforce in the Participant the link between classroom learning and work requirements.

Behavioral Standards:
• Participants will be respectful and courteous to patients, family members, and staff at all times.
• Participants will not touch patients. If participants are allowed to observe a patient during a procedure, the director or manager must obtain the patient's consent first, or if the patient does not have capacity, the director or manager must obtain the consent of the patient's legal representative
• Participants will not make any decisions regarding or render any advice or recommendations as to the treatment or care of patients.
• Participants will not touch medical equipment.
• Participants will not have medical record, chart, or computer access.
• Participants will not assist in feeding a patient but may assist in food delivery.
• Participants will not approach physicians about personal illness or medications.
• Participants will dress professionally. NO jeans or shorts; scrubs or lab coats; sandals or flip-flops; dangling jewelry.
• Participants will not be permitted to wear scrubs or lab coats, as they are reserved for the care provider team.
• Participants will not perform personal care in the clinical setting (i.e. eating or drinking, brushing hair, etc.)
• Participants will not be permitted in areas of contamination, such as isolation rooms, soiled linen areas, labs, and autopsy rooms.
• Participants cannot participate in the program on days they are ill, including but not limited to, Cold/Cough, Fever (must be fever-free for 24 hours), Chicken Pox, Pertussis (Whooping Cough), Influenza (Respiratory Flu), Stomach/Gastrointestinal Flu, Tuberculosis, MRSA.
• Participants will not need a purse, cell phone, or backpack; no storage will be available on-site for personal items.
• Cell phone use is not permitted.
• Ochsner is not liable for any theft or damage to personal property while you are on campus for your job shadow. It is best to leave important personal items at home.

If interested in a Job Shadow experience at Ochsner Medical Center-New Orleans, please review the educational PowerPoint available online, then complete and submit the following forms to volunteerservices@ochsner.org:

1. Job Shadow Application
2. Participant Agreement/Release

You will be contacted as soon as a mentor is identified to discuss your schedule availability.

For any questions, please call 504-842-5085 or email volunteerservices@ochsner.org.
# Adult Job Shadow Application

## Participant Contact Information

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<tr>
<th>Name</th>
<th>Last</th>
<th>First</th>
<th>Middle</th>
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<tr>
<th>Home Address</th>
<th>Street Number</th>
<th>Street Name</th>
<th>Apt</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
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| E-Mail Address | | |
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<tr>
<th>Birth Date</th>
<th>Phone Number (<strong><strong><strong>) (</strong></strong></strong>) – (______)</th>
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<tbody>
<tr>
<td>Month</td>
<td>Day</td>
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## Emergency Contact Information

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<th>Name</th>
<th>Relationship</th>
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<th>Primary Phone (<em><strong><strong>) (</strong></strong><strong>) – (</strong></em>___)</th>
<th>Secondary Phone (<em><strong><strong>) (</strong></strong><strong>) – (</strong></em>___)</th>
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## Placement Information

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<th>Classification:</th>
<th>□ College Student</th>
<th>□ Post-Graduate/Professional</th>
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In what field of study/department/career are you looking to complete your job shadow?

___________________________________________________________________________________________

Do you already have a mentor confirmed? □ YES □ NO

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<th>(If yes) Mentor’s Name:</th>
<th>Department:</th>
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Job shadow opportunities are provided without regard to religion, creed, race, national origin, age or sex. This application is submitted with understanding that approval from the authorized Ochsner designee must be in place prior to commencing the shadow as a condition to begin. I certify that the answers given to the foregoing statements are correct and without omission. I authorize the company to investigate the foregoing; and my former employers from any liability for damage, which may result from any such investigation. If upon investigation, anything contained in this application is found to be untrue, I understand I will be subject to dismissal at any time during the period of shadowing. Ochsner is not obligated to provide a placement, nor am I obligated to accept the placement offered. I understand that if accepted, I will schedule my placement in a timely manner. I also understand that I will not be paid for this experience.

___________________________________________________________________________________________

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<tr>
<th>Participant Signature</th>
<th>Participant Printed Name</th>
<th>Date</th>
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Ochsner Medical Center – New Orleans
Health Career Exploration/Job Shadow
Participant Agreement

I, _____________________________________, have been selected to participate in a job shadow to
seek further insight into a particular department in order to gain personal understanding and general
knowledge related to job function and environment.

**Consent:** I give permission to have myself photographed and/or videotaped while participating in any
Program by Ochsner Clinic Foundation and all its affiliates (together “Ochsner”) for use by Ochsner in
all public relations activities, including use by or for news media, and further authorize the use of my
name with said photos, film, print or tape in all advertising activities, including television commercials,
print ads, brochures, web sites, and outside billboards.

**Release.** In consideration of being allowed to participate in the Program, I hereby release Ochsner
Clinic Foundation, as well as its subsidiaries, affiliates, representatives, agents, physicians, employees,
servants, officers, directors, insureds, insurers, successors, and assigns (collectively “Ochsner”) from
any and all liability for any injury or damage which may occur as a result of my participation in the
Program including all risk connected therewith, whether foreseen or unforeseen; and further, agree to
save and hold harmless Ochsner from any claim by myself individually or on behalf myself, family,
estate, heirs or assigns arising out of my participation in the Program.

In the event of an injury requiring medical attention, I hereby grant permission to Ochsner to provide
initial medical services to me. If the injury warrants further medical attention, I expect every effort will
be made to receive my specific authorization before action is taken. If efforts are unsuccessful, I grant
permission for necessary medical treatment to be given. In addition, I hereby give my permission to the
supervising instructor(s) or Ochsner staff (including medical staff) to take me to the appropriate medical
department for treatment within the hospital or, if a physician, to administer treatment if an accident or
serious illness occurs. Under all circumstances, I agree to accept full responsibility for and to pay for
the cost of any medical care, transportation and other incidental expenses for any medical treatment or
services I receive at Ochsner.

**HIPAA Acknowledgement:** My signature below indicates I have read and understand information
related to HIPAA and my responsibilities while shadowing at Ochsner. I acknowledge that there are
civil and criminal penalties for the unauthorized access and/or use of confidential patient information. I
will adhere to the guidelines as outlines in the training provided.

__________________________
Participant Signature

__________________________
Date

__________________________
Printed Name

__________________________
Phone Number