VISITING OBSERVER APPLICATION
(Respiratory Job Shadow Application)

Individuals wishing to perform observation of hospital activities must submit this "Job Shadow" application to the Respiratory Care Department, 3700 Washington Avenue, Evansville IN 47750 (mail or hand deliver) or scan and email to Nmorgan@ascension.org . Applications must be received a minimum of 2 business days in advance of the desired observation date. Preferred job shadow schedule to occur during the months of May, July, August and December, the day before or after Thanksgiving, or during the week of USI Spring Break.

On the day of your Job Shadow, for Professional Dress, Hygiene concerns and Personal Safety, please ensure the following:

1. Business casual / Professional Appearance attire (Wearing Khaki pants or dress pants, collared "polo" style shirt or button down shirt, or hospital scrubs, no jeans). Not extreme clothing or words on clothing.
2. No open toed shoes, needs to be a comfortable, full leather shoe, socks above ankles.
3. Good personal hygiene, including no perfume or cologne or other unpleasant or unnatural odor on body or clothing, hair groomed, and no visible tattoos or body piercings (cover any visible tattoos).
4. Report to the Respiratory Care Department, 2nd floor of the Main Hospital, arrive on time, plan to stay the agreed upon hours, and no cell phones in patient care areas.

Name *(Please Print)* ____ Date:_______________________
First *Middle Int.* *Last*

Address: ____

City, State, Zip: ____

Daytime telephone: ______________________________ E-mail address: _____________________________

Emergency Contact Name: __________________________________Phone Number: (_____) _____________

Date and time of requested observation ____

What staff or activity do you wish to observe? ____

Why do you wish to perform this observation? ____
____

Visiting observers are required to have a staff sponsor. The sponsor will escort you during your visit and assure that, to the extent practicable, you have been given the information you are seeking. If you have identified a staff sponsor, please enter the name below. If you have not identified a sponsor, one will be provided for you. *If staff is available.*

Name of sponsor *(print):* ________________________________ Department: _Respiratory Care_________

Personal information:

1. Are you presently a student? ☐ Yes ☐ No
   If yes, where do you attend school? ____

2. Are you presently employed? ☐ Yes ☐ No
   If yes, who is your employer? ____

3. Health screen:
   Do you have a past history of TB? ☐ Yes ☐ No
   Have you had a TB skin test within the last year? ☐ Yes ☐ No
   Have you been immunized against the following? ☐ Yes ☐ No

Rubella	☐ Yes ☐ No	Measles	☐ Yes ☐ No
Mumps	☐ Yes ☐ No	Chickenpox	☐ Yes ☐ No
Hepatitis A	☐ Yes ☐ No	Hepatitis B	☐ Yes ☐ No

PLEASE NOTE: St. Vincent Evansville reserves the right to terminate the observational experience of any person who shows signs of communicable disease. If you are suffering from a cold, flu, fever, diarrhea or other indicator of communicable illness, PLEASE CANCEL YOUR OBSERVATION AND RESCHEDULE.

This form must be returned to the Volunteer Services Department a minimum of 5 days prior to the desired date of observation. St. Vincent Evansville reserves the right to deny any application or to terminate the observational experience of anyone who fails to observe the Visiting Observer policy requirements.

CONFIDENTIALITY AGREEMENT FOR VISITORS

I, ____ *(Please Print Name)*, a Visitor at St. Vincent Evansville understand that I must keep in strictest confidence all information about patients that I may acquire while visiting at the Hospital. I agree not to discuss or reveal in any way the identity of patients at the Hospital, any information about their medical conditions, or any other patient information which I may learn while helping with organized activities of the Hospital. I understand that if I breach this obligation of confidentiality, I may cause harm to a patient and could be required to respond in damages to such a patient for such possible harm. For more information, use the hyperlink below.
https://www.hhs.gov/hipaa/for-professionals/security/laws-regulations/index.html

______________________	________________________________
Date	Signature of Visitor
______________________	________________________________
Date	Signature of Parent or Guardian, if Visiting Observer is under age 18

Return this form to the Respiratory Care Department at St. Vincent Evansville, 3700 Washington Avenue, Evansville IN 47750 or email Nmorgan@ascension.org . Respiratory Phone number for questions/confirmation that application was received and confirm scheduled dates: (812) 485-4824.
Failure to return this form will result in denial of participation.