Davis HealthSystem
812 Gorman Avenue • Elkins, WV 26241 • 304.637.3767 • Fax 304.637.3435 • davishealthsystem.org

JOB SHADOWING

Thank you for your request for a student externship at Direct Care of Elkins. We are happy to accommodate your request.

Employee Health requires completion of the attached Student Clinical Requirements form. Please complete, sign and date the form and return it to my attention via fax or email (see contact information below).

You must also provide: (1) A copy of your immunization records to validate the **dates of all vaccinations stated on the form above**; and (2) written verification of a recent PPD result (skin test for tuberculosis). If you have not had a PPD within the past 12 months, you can have it done here at no cost. Just let me know in advance so that I can alert Employee Health that you are coming to have it done.

DMC's required panel for the drug screen must include: Amphetamines, Barbiturates, Benzodiazepines, Cocaine, Opiates, PCP, Marijuana, Buprenorphine Reno (Suboxone), and Alcohol. Please give this information to your PCP to write on the order for the drug screen in order to avoid any delay. I believe your program coordinator can assist you in getting this accomplished. We will need a copy of the results of the drug screen before you begin your externship.

After the paperwork is returned to me and approved by Employee Health, I will schedule an appointment with you for a brief hospital orientation. This must take place prior to your first day at Direct Care and you will have your photo taken at that time for a facility ID badge. Orientation appointments must be scheduled in advance.

Please let me know if you have any questions or concerns. Thank you.

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Job Shadowing Request

Name:_____

Date of Birth: ____/____/_____

Address:_____(Street) _____(City) _____(State/Zip)

Telephone: _____E-mail:_____@_____.com

Education:

High School: ❍Yes ❍No

College: ❍Yes ❍No

Major:_____

Anticipated Graduation Date:_____

Post Graduate: ❍Yes ❍No

Post Graduate Degree:_____

Have you observed/shadowed at Davis Health System in the past? ❍Yes ❍No

If you answered yes to the above, please provide the date(s) and department(s) of your job shadowing experience:_____

Have you ever been employed by Davis Health System (Davis Health System or Broaddus Hospital)?
❍Yes ❍No

If you answered yes to the above, please provide facility name, dates of employment, job title, and department:

_____

Have you been convicted of or pled no contest to any crime in the past seven years? ❍Yes ❍No
If yes, please explain (a conviction or having pled no contest does not necessarily disqualify you from participating):_____

Goal:

What dates are you available to shadow? From _____ to _____ (mm/dd/yyyy)
What department/profession are you interested in shadowing? _____
What is your goal/objective of your job shadowing experience at Davis Health System?_____
_____

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Verification of Immunization/Student Clinical Requirements

Last name:	First name:	DOB:
School:	Phone Number:	Rotation Department:

The following clinical requirements and immunizations and/or titers must be up-to-date and this completed form on file at Davis Medical Center before clinical rotations may start. Copies of the following records must remain on file at the college/university/school and be accessible if requested by DMC and/or accrediting agencies. The requirements were developed in response to Joint Commission standards.

Hepatitis B			Include Month & Year
Immunized	Yes ____	No ____	If yes, date(s): #1 _____ #2 _____ #3 _____
Positive Titer	Yes ____	No ____	If yes, date:
MMR			
Immunized	Yes ____	No ____	If yes, date(s): #1_____ #2_____
Positive Titer	Yes ____	No ____	If yes, date:
Varicella			
Immunized	Yes ____	No ____	If yes, date(s): #1_____ #2_____
Positive Titer	Yes ____	No ____	If yes, date:
Tdap			
Immunized	Yes ____	No ____	If yes, date:
Influenza			
Immunized	Yes ____	No ____	If yes, date: Lot# Expiration Date:
PPD			
2-step (2 separate tests not more than 1 year apart) **OR** Chest X-Ray if PPD positive	Yes ____ Yes ____	No ____ No ____	If yes, date(s): #1_____ #2_____ If yes, date:
CPR AHA Health Care Provider Class	Yes ____	No ____	If yes, expiration date:
Drug Screen	Yes ____	No ____	If yes, date:
Physical Exam	Yes ____	No ____	If yes, date:
Criminal Background Check	Yes ____	No ____	If yes, date:

Note: For Drug Screen, Physical Exam and Criminal Background Check, date upon acceptance into school/program is permissible. These are not required to be repeated.
Note: If student is shadowing (no physical patient contact, observation only), it is not required to provide proof of Drug Screen, Physical Exam, Criminal Background Check or CPR certification.
Note: If selected "No" response for vaccination and/or titer, please provide documentation from medical provider as to indication for declination.

I hereby certify that the above information is true and accurate to the best of my ability.

Signature(Guardian if student a minor):_____ **Date:**_____

RETURN THIS FORM TO Fitzwater.char@dhswv.com OR fax to 304-637-3384

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DEPARTMENT: INFECTION PREVENTION	POLICY DESCRIPTION: REQUIREMENTS FOR STUDENTS PERFORMING CLINICAL ROTATIONS
PAGE: 1 of 3	REVISED: 1/1/2014
REVIEWED: 1/9/2017	RETIRED:
EFFECTIVE DATE: 1/9/2017	REFERENCE NUMBER:

Purpose: To provide uniform guidelines for ensuring all nonemployees/students in the hospital are free from communicable disease or any other diseases, which may be debilitating or render the nonemployee from being able to perform his/her assigned duties in a safe and effective manner. The requirements were developed in response to Joint Commission standards.

Policy:

- Verification of Immunization/Student Clinical Requirements form is mandatory and must be completed, signed and turned in by the college/university/school before the student may enter the hospital and/or affiliated sites. Clinical rotations will not be considered unless the form has been submitted to the Humans Resources Department.
- The Verification of Immunization/Student Clinical Requirements form will be renewable on a yearly basis.
- Copies of the student records, including proof of vaccination, titer results, physical exam and drug screen results must be filed and maintained by the college/university/school and be accessible if requested by Davis Medical Center and/or accrediting agencies.

Procedure:

- It is the responsibility of the college/university/school to contact the Human Resources Department for the Verification of Immunization/Student Clinical Requirements form prior to arranging clinical rotations.
- The Human Resources Department is responsible for ensuring the Verification of Immunization/Student Clinical Requirements form completed prior to the start of clinical rotations and annually thereafter.
- Nursing Education and/or The Office of Medical Staff Services/Physician Recruitment will communicate with the Human Resources Department regarding prospective students and/or residents prior to any clinical rotations.
- The Infection Preventionist/Employee Health Nurse is responsible for ensuring that the Verification of Immunization/Student Clinical Requirements form is compliant with current medical/physical recommendations as defined in hospital employee health policy.
- The following clinical requirements and immunizations and/or titers must be up-to-date before clinical rotations may start:

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Required Vaccinations and/or Positive Titer

- Hepatitis B
- MMR
- Varicella
- Tdap
- Influenza
- PPD 2-step (2 separate tests not more than 1 year apart as baseline, then annually thereafter) **OR** Chest X-Ray if PPD positive

Additional Requirements

- CPR (AHA Healthcare Provider Class)
- Drug Screen (date of drug screen upon acceptance to school/program is permissible)
- Physical Exam (date of physical exam upon acceptance to school/program is permissible)
- Criminal Background Check (date of criminal background check upon acceptance to school/program is permissible)

Shadowing

- If student is shadowing (no physical patient contact, observation only), it is not required to provide proof of Drug Screen, Physical Exam, Criminal Background Check or CPR Certification

APPROVALS:

_____ _____
Infection Preventionist Date

_____ _____
CNO Date

_____ _____
Chief of Medical Staff Date

_____ _____
Chief Human Resource Officer Date

Reviewed By: _____ *Date:* _____

Reviewed By: _____ *Date:* _____

Reviewed By: _____ *Date:* _____