

Today's Date: _____

Type:

- ☐ Intern (non-paid)
☐ Clinical Observer (Job Shadow)



Application

Name: _____ Date of Birth: _____

Home Address: _____
Street Address

City, State Zip Code

Campus Address: _____
If applicable Street Address City, State Zip Code

Name of School: _____ Grade: _____ Graduation Year: _____

Home Phone: _____ Cell Phone: _____ Business Phone: _____

Email: _____

Emergency Contact: _____ Relationship: _____

Phone: _____

Area Preference: _____

Please list the name of staff member whom you will be observing or completing internship

Name and Area: _____

Email Address: _____

How did you learn about Beacon Health System's Clinical Observation/Intern Program?

*I certify that the information above is correct to the best of my knowledge. I promise that I will not divulge any information that I shall see or hear, and I will keep confidential any information released to me during my experience at Beacon Health System and that I will abide by Beacon's Values and Performance Essentials. I may **not** participate in the program before all required paperwork and immunizations records are turned in.*

Signature

Date

I give permission for my child to participate in the Non-Paid Intern or Clinical Observation program(s) offered at Beacon Health System. I agree that my child will abide by Beacon Health System's Volunteer Standards of Conduct and Performance Essentials.

Parental Permission Signature (if under 18)

Date



**Clinical Observation
Personal Loss/Injury/Illness Release Form**

- Beacon Health System is not responsible or liable for any theft or loss of personal items that may occur while participating in this educational activity.
- Beacon Health System is not responsible or liable for any injury, or bodily harm that may occur while participating during this educational opportunity.
- Beacon Health System is not responsible or liable for any illness that may occur while participating during this educational opportunity.

Student Name: _____

Please print

Date: _____

I fully understand and agree to the above statements:

Student/Individual Signature

Parent/Guardian Signature (if under 18)

Date



Performance Essentials

Mutual Respect:

I commit to consistently practice the following respectful behaviors:

- I will always approach the person I have an issue with assuming good intent.
- I will always seek to resolve problems in a collaborative and mutually respectful manner.
- I will be mindful of individual differences, and cultural and ethnic diversity.
- I will not participate in or listen to non-collaborative conversations regarding other members of the team. I will stop the conversation and direct the person(s) involved by saying "In respect of _____, I prefer you speak directly to them."
- I will receive feedback in a collaborative manner.
- If I am unable to resolve an issue with my co-worker on my own, I have the responsibility and will seek my manager's assistance to help me facilitate a positive resolution.

Student/Individual Signature

Date: _____

Parent/Guardian Signature (if under 18)

Date: _____

Dress Code:

I commit to consistently follow the dress attire:

- *Shirt:* Collared button-ups in any color; Colored shirts and blouses (avoid low-cut shirts or bright patterns)
- *Pants:* Casual slacks should be worn; NO denim, shorts, sweats, or leggings
- *Shoes:* Walking shoes are suggested; NO open-toed shoes or sandals
- *Badge:* Your temporary observer badge must be worn at all times and visible above the waist
- *Dress Code Restrictions:* No false finger nails, excessive jewelry, tattoos, and/or piercings

Student/Individual Signature

Date: _____

Parent/Guardian Signature (if under 18)

Date: _____



Clinical Observer/Intern Statement of Confidentiality and Non-Disclosure Agreement

Beacon Health System and subsidiaries has a policy of preserving the confidentiality of medical, staff member, proprietary and other information regarding activities and treatments provided in our facilities. Policies and procedures pertaining to the release of information are established to protect the privacy of patients, staff members, prospective staff members and others, to provide this information to authorized persons for medical care, insurance and legal matters, and to protect all information from inappropriate use or disclosure. Beacon Health System's online policy and procedure manual contains the guidelines for the release of protected health information, and similar policies and procedures may be found on the Beacon Health System intranet or designated locations.

The information contained in the medical, staffing, financial, computerized and other records of Beacon Health System and subsidiaries are the property of Beacon Health System and subsidiaries. A professional, ethical and legal obligation exists on the part of Beacon Health System and subsidiaries to protect the confidentiality of the information contained in these records.

Violation of these policies and procedures will make the student and his/her university or the vendor representative and his/her company subject to disciplinary actions up to and including immediate removal from Beacon Health System and subsidiaries and prohibition from future contact at Beacon Health System and subsidiaries.

The essence of these policies and procedures are restated in the following guidelines for the use and disclosure of medical, staff member, proprietary and other information of Beacon Health System and subsidiaries.

1. Original records should not be removed from their location except as ordered by appropriate personnel or legal authorities.
2. Students or vendor representatives granted record access are accountable for the protection of the record and its contents while it is in his/her possession and will not allow the record or the information in the record to be used or disclosed to third-parties without the expressed approval of Beacon Health System and subsidiaries.
3. Students or vendor representatives will not at any time during or after his/her affiliation with Beacon Health System and subsidiaries disclose medical, staff, proprietary or other information of Beacon Health System and subsidiaries.
4. Students or vendor representatives granted access to computer systems at Beacon Health System and subsidiaries will not at any time attempt to access his/her own medical information, medical, staff, proprietary or other information for which they do not have a legitimate reason to do so and will secure access to the computer when it is not in use. This information includes, but is not limited to, the medical, staff, proprietary and other information of family, friends, business associates, patients and staff members.
5. Students or vendor representatives granted access to medical, staff, proprietary or other information shall follow all Beacon Health System and subsidiaries policies and procedures on the handling, storage and disposal of medical, staff, proprietary or other information.
6. Students or vendor representatives granted access to computer systems at Beacon Health System and subsidiaries will not share or disclose their computer sign on nor attempt to learn another person's computer sign on. If the student or vendor representative believes his/her computer sign on has been learned by another person, the student or vendor representative will contact the Security Administrator or a Management person immediately.

Student Name: _____

Please print

Student/Individual Signature

Date: _____

Parent/Guardian Signature (if under 18)

Date: _____



Safety Quiz

Please circle True or False

- | | | |
|--|---|---|
| 1. Only Clinical Staff are responsible for patient safety. | T | F |
| 2. You are responsible for assuring the safety of your work environment. | T | F |
| 3. When approaching patients or visitors you should not make eye contact. | T | F |
| 4. Speaking first with a friendly greeting is good customer service. | T | F |
| 5. There is no need to speak quietly when around patient rooms or meeting rooms. | T | F |

Please fill in the blank

6. What is a Code Red:

7. What is a Code Blue:

8. What does the Code Word for how to respond to a FIRE (**R-A-C-E**) mean?
R _____ A _____
C _____ E _____
9. What do the 4 steps (**P-A-S-S**) of using a Fire Extinguisher mean?
P _____ A _____
S _____ S _____
10. What is the length of time the Indiana Department of Health says hands must be lathered with soap and water for hand washing? _____ seconds

Student Name: _____

Please print

Student/Individual Signature

Date: _____

Parent/Guardian Signature (if under 18)

Date: _____