The Permanente Medical Group
Central Valley Service Area
Non-Program Affiliated Individual Onsite Experience

Application Cover Page and Attestation

Thank you for your interest in a job shadow at Kaiser Permanente. This packet contains materials you need to read, complete, and sign. If you are under the age of 18, your parent will also need to sign each document.

In order to be accepted the application packet needs to be filled out completely. If you have any outstanding vaccinations, including TB, please do not apply until those are completed. Application period starts on the 1st of each month.

Documents you will be asked to complete or provide:

1. Cover Page and Attestation
2. Information Sheet
3. Health Record Immunization Sheet
    - This page must be filled in with dates AND attach an immunization record from your health care provider in the application.
4. Liability and Photo Release Consent
5. Emergency Contact Information
6. Confidentiality Agreement

I attest that I, _____, have read, reviewed/completed, and understand all materials provided to me in this packet. I understand that Kaiser Permanente can decide to terminate my shadow experience at any time, for any reason without notice.

(Signature) (Date)

(Parent/Guardian Signature, if under 18) (Date)

The Permanente Medical Group
Central Valley Service Area
Non-Program Affiliated Individual Onsite Experience

Information Sheet

Name:	**Date of Birth:**
Address:	
City: Zip:	
E-Mail Address:	**Phone:**

PLEASE PROVIDE A COPY OF PHOTO IDENTIFICATION (DRIVERS LICENSE OR STUDENT ID

Have you ever been employed by Kaiser Permanente? **Yes** **No**	**If yes, name of facility:** **When:** **Position Held:**

Do you have a Physician/Staff at Kaiser Permanente who has agreed to be your Host during this onsite experience? If so:

Name:_____ Phone:_____

Department(s) to which your host works (if known)

_____

Desired Length of Job Shadow (No more than 150hrs per experience)

Date(s)_____ **Start/Stop Time** _____

The Permanente Medical Group
Central Valley Service Area
Non-Program Affiliated Individual Onsite Experience

Health Record

Please fill out immunization dates below AND attach an immunization record from your health care provider in the application

Requirement	Documented Date (attach documentation)
Documentation of 2 Negative PPDs (1 within the last three months and 1 within the last 24 months) OR If participant has prior positive PPD, chest x-ray with physician documentation (no older than 12 months) verifying that participant has no active TB. *If both TB test are not complete at time of application, please refrain from applying until tests are complete. Any pending test results will not be approved at this time*	Date of #1 TB/PPD: _____ Date of #2 TB/PPD: _____
	If positive, date of chest X-Ray
	If positive, date of symptom free review
Documentation of either serological testing demonstrating immunity or proof of up-to-date immunization for:	Rubeola (Measles): Date _____ Result _____
	Mumps: Date _____ Result _____
	Rubella: Date _____ Result _____
	Varicella zoster (chicken pox): Date _____ Result _____
	Varicella: Date _____ Result _____
	Tdap Vaccine: Date _____ Result _____
Documentation of having been immunized with Hepatitis B vaccine series (First dose in series completed at minimum) or demonstrated immunity.	Hepatitis B: Date _____ Result _____
Proof of vaccination for Influenza.	Flu Vaccine: Date _____
Proof of vaccination for CoVid.	Date of #1 CoVid Vaccine:_____ Date of #2 CoVid Vaccine:_____ Date of CoVid Vaccine Booster_____

The Permanente Medical Group
Central Valley Service Area
Non-Program Affiliated Individual Onsite Experience

Liability Release

I, _____, Job Shadow Participant or Parent/Legal Guardian of _____, a minor child, hereby consent to participate in a Job Shadow Program at Kaiser Permanente, Central Valley. I understand the importance of confidentiality and privacy in health care, as well as the importance of infection control and need for hand washing, as instructed by the participant's host.

I understand that there may be hazards involved in my shadow experience at Kaiser Permanente. Participation may include exposure to radiation, hazardous materials, communicable diseases, including blood borne pathogens. I will shadow my Host and follow all safety instructions he or she provides.

I understand that photographs, recordings, and/or images may be obtained while I (or the minor, if under 18) am shadowing. I agree that Kaiser Permanente may use, publish, copy, exhibit, or distribute these images as determined by Kaiser Permanente.

If the participant is under 18 years old, a parent or guardian has spoken with him or her about the need to maintain confidentiality around the shadow visit and to follow all infection control and safety instructions from his or her Host.

_____

Participant signature

_____

Participant Name (print) Date

_____

Parent/Guardian signature (if participant under 18)

_____

Parent/Guardian (print) Date

The Permanente Medical Group
Central Valley Service Area
Non-Program Affiliated Individual Onsite Experience

Emergency Information

The Job Shadow Participant has the following allergies or medical conditions:

_____

_____

Medical Insurance Carrier:_____

Physician Name/Phone # _____

Policy #_____

Group #_____

Emergency Contact Information (2)

Name: _____

Relationship: _____

Phone Number(s):_____

Name: _____

Relationship: _____

Phone Number(s):_____

KAISER PERMANENTE®

2870

CONFIDENTIALITY AGREEMENT

Note: Applies to all employees (including administrators, managers, supervisors, applicable physicians), volunteers, agency temporary/registry personnel, students and interns.

* Student ID	* Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
* Student First Name	Student Middle Name	* Student Last Name
* Job Title	* Location	

1. AGREEMENT

In my job, I may see or hear confidential information in any form (oral, written, or electronic) regarding:

- HEALTH PLAN MEMBERS AND PATIENTS AND/OR THEIR FAMILY MEMBERS (such as patient records, test results, conversations, financial information)
- EMPLOYEES, PHYSICIANS, VOLUNTEERS, CONTRACTORS (such as employment records, corrective actions/disciplinary actions)

I will protect the confidentiality of this information. Access to this information is allowed only if I need to know it to do my job.

I AGREE THAT:

1. I will protect the confidentiality of our patients, members, employees and physicians.
2. I will not misuse confidential information and I will only access information I have been instructed or authorized to access to do my job. With respect to Medical Information, I will only access or use such information as it is necessary to provide medical care to the member and/or patient or as necessary for billing and payment or health plan operations.
3. I will not share, change or destroy any confidential information unless it is part of my job to do so. If any of these tasks are part of my job, I will follow the correct department procedure or the instructions of my supervisor/chief of service (such as shredding confidential paper). If a demand is made upon me from outside Kaiser Permanente to disclose confidential information, I will give written notice to my supervisor before disclosing such information.
4. I know that confidential information I learn on the job does not belong to me and that Kaiser Permanente may take away my access to confidential information at any time.
5. If I have access to electronic equipment and/or records, I will keep my computer password secret and I will not share it with any unauthorized individual. I am responsible if I fail to protect my password or other access to confidential information.
6. I will not use anyone else's password to access any Kaiser Permanente system unless I am authorized to do so. If I am authorized to do so (e.g., in order to perform computer systems maintenance), I will follow procedures to ensure the password is changed and that confidential information is not at risk.
7. If I have access to electronic equipment and/or records, I will not make unauthorized copies of Kaiser Permanente's software or software of other companies licensed for use by Kaiser Permanente and I will use software in compliance with the terms of any applicable software license agreements.
8. I will not share any confidential information even if I no longer work for Kaiser Permanente.
9. On termination of my employment, I will return to Kaiser Permanente all copies of documents containing Kaiser Permanente's Confidential information or data in my possession or control.

KAISER PERMANENTE®

* First Name	Middle Name	* Last Name
* Student ID	* Phone Number (###)###-####	* Effective Date (mm/dd/yyyy)

Examples of Breaches of Confidentiality (What you should NOT do.)

These are examples only and do not include all possible breaches of confidentiality.

- Unauthorized reading of patient account information.
- Unauthorized reading of a patient's chart (except your own if you have access to electronic records).
- Unauthorized access to information on friends or co-workers.
- Accessing medical information of a family member without written authorization.
- Discussing confidential information in a public area such as a waiting room or elevator.

Examples of Breaches of Confidentiality related to electronic information (What you should NOT do.)

These are examples only and do not include all possible examples of breaches of confidentiality.

- Telling a co-worker your password so that he or she can login to your work.
- Telling an unauthorized person the access codes for employee files or patient accounts.
- Being away from your workstation while you are logged into an application, without locking your system to protect confidential information.
- Unauthorized use of a co-worker's password to logon to a Kaiser Permanente information system
- Unauthorized use of a user ID to access employee files or patient accounts.
- Allowing a co-worker to use your *secured application for which he/she does not have access after you have logged in.

NOTE: * secured application = any computer program that allows access to confidential information. A secured application usually requires a user name and password to log in.

I understand that I am responsible for my use or misuse of confidential information and know that my access to confidential information may be audited. I understand that my supervisor/chief of service or other managers and/or the Compliance Hot Line are available if I think someone is misusing confidential information or is misusing my password. I further understand that Kaiser Permanente will not tolerate any retaliation because I make such a report.

I understand that failure to comply with this agreement may result in disciplinary action up to and including termination of employment or other relationship with Kaiser Permanente. I understand that I may also be subject to other remedies allowed by law. I understand that I must also comply with any laws, regulations, and other Kaiser Permanente policies, including the Principles of Responsibility that address confidentiality. By signing this Confidentiality Agreement, I agree that I have read, understand and will comply with it.

2. SIGNATURE (Required if not submitted online)

* Student Signature	* Date (mm/dd/yyyy)
* Parent/Guardian signature (if participant under 18)	* Date (mm/dd/yyyy)