Providence Alaska Region

Shadow Application Packet

Providence St. Joseph Health provides shadow experience to individuals seeking a deeper understanding of the professional medical field. Providence Alaska Medical Center, Providence Seward Medical Center, Providence Valdez Medical Center, Providence Kodiak Island Medical Center, and Providence St. Elias Specialty Hospital (collectively, Providence Alaska) supports shadowing opportunities for persons interested in a career in the medical professional field.

Providence Alaska promotes healthcare careers by offering individuals opportunities to shadow and to have an on-the-job experience with a medical staff member or allied health professional (AHP) who is on staff at the applicable Providence Alaska facility. The medical staff member or AHP is responsible for providing supervision and an optimal learning experience.

Those requesting to participate in the shadow program shall contact the Medical Staff Services Department, located at Providence Alaska Medical Center, for an application and return all necessary materials and documentation to the Graduate Medical Education Program Coordinator.

Medical Staff Services Department
Providence Alaska Medical Center
3200 Providence Dr. Suite C520
Anchorage, AK 99508
Phone: (907) 212-3185
Fax: (907) 212-4865
AKMedicalStaff@Providence.org

Providence

CONTENTS

SECTION ONE

Providence

SHADOW PROGRAM POLICY

PURPOSE/SCOPE

The purpose of this policy is to describe shadowing opportunities coordinated through Providence Alaska Medical Staff Services Department (MSSD), located at Providence Alaska Medical Center (PAMC), for persons interested in a career in the medical profession. The Medical Staff at Providence Alaska facilities promote healthcare careers by offering individuals opportunities to shadow a Medical Staff member or Allied Health Professional (AHP) on staff at the applicable Providence Alaska facility. The Medical Staff member or AHP would be responsible for providing supervision and an optimal learning experience.

POLICY

In keeping with the philosophy and mission of Providence Health & Services Alaska (PHSA) Region, Providence Alaska offers a variety of experiences allowing individuals progressing in or towards the medical profession to observe medical professionals (physicians and allied health professionals) in their work setting.

DEFINITIONS/ACRONYMS

Shadow: An individual at least 16 years of age, interested in a career in the medical professions that applies to observe a member of the Medical Staff and/or AHP staff. A Shadow may be an individual other than a student who has arranged an opportunity to shadow (strictly observe) a physician or AHP.

Observational Experience: A designated time frame in which the shadow may observe the practices of a member of the Medical Staff and/or AHP staff. The maximum allowable experience is a 90-day time frame.

SPECIAL CONSIDERATIONS

This program is not intended for providers who are waiting to be credentialed or in lieu of being credentialed.

PROCEDURES

Shadow Responsibilities

1. The Shadow is responsible for conducting themselves appropriately demonstrating respect, courtesy and consideration of others. Shadows are responsible for following appearance standards, maintaining confidentiality related to all information they may hear, directly or indirectly, concerning a patient, doctor, or any facility personnel.
2. While in the facility, the Shadow must wear an identification badge at all times.
3. All shadow experiences are under the direct supervision of an approved physician or AHP.
4. An application must be completed by the applicant. The application must then be returned to, and approved by, the MSSD at least one week prior to the shadow's experience start date.
5. Shadows must meet all requirements listed within the application.
6. Shadows are responsible for coordinating their own observational experience and obtaining the signature(s) of their supervising practitioner(s).
7. Shadows are not allowed to touch, treat, or otherwise contact the patient.

Medical Staff Services Department Responsibilities

1. Ensure completion of necessary documentation by the applicant.
2. If a Shadow is under 18 years of age, require written, signed consent form the parent/legal guardian prior to the scheduled experience, stating related of liability for Providence Alaska and permitting the learning experience.
3. Provides an identification badge that must be worn in a visible location on outer clothing at all times when in the facility.
4. Provides the Shadow with an orientation outlining responsibilities during the observational experience. Provides information and documentation on safety, confidentiality, standards, and release prior to the scheduled experience.

Supervising Physician / AHP Responsibilities

1. A medical staff/AHP member accepting the role of supervisor is responsible for providing a positive learning experience for shadows.
2. The medical staff/AHP member designates the appropriate times for shadow observation.
3. The supervising medical staff/AHP member is responsible for obtaining consent prior to shadow observation of procedures or surgery. Patient's consent shall be documented in the medical record. Shadows are not allowed to touch, treat, or otherwise contact the patient.
4. Consent may be verbal and must be documented to include that the shadow did observe.

Providence Alaska Responsibilities

1. To provide an atmosphere of learning that meets the learning objectives for shadows during the observational experience.

Providence

SHADOW APPLICATION

Instructions: Students and Professionals seeking to participate in the shadowing of a practitioner must fill out this application, the other forms listed, and provide any requested additional documentation **at least two weeks prior to the shadowing experience.** Clearly state NOT APPLICABLE or N/A if the section or question is not relevant to you. Ensure that required documentation is attached (as listed in Section F of this application) and return to AKMedicalStaff@Providence.org.

SECTION A: PERSONAL INFORMATION

Name (first, middle initial, last)			Degree (if applicable)
Gender	Email Address	Phone Number	
Home Street Address			
City		State	Zip
Date of Birth	Age	Birth City	Birth State/Country
Other names by which you have been known:			

SECTION B: EXPERIENCE INFORMATION

Date of Application	Dates of Shadow Experience From (MM/DD/YYYY) To (MM/DD/YYYY)
Specialty/Area During Shadowing Experience	
Name of Supervising Practitioner	Facility:

Providence

SECTION C: EDUCATION AND TRAINING

*If you are already a practitioner, or are not currently enrolled in an educational program, please move on to Section D. Please note that your Program Coordinator may be contacted as a character reference.

Current Level of Education (Circle One)	High School	Undergraduate	Graduate
Name (Educational Institution)			
Program/Degree Seeking (university level only)		Start Date	Graduation Date
Street Address			
City/State	Zip	Program Coordinator Name	
Program Coordinator Email Address		Program Coordinator Phone	

SECTION D: EMPLOYMENT

*Please note that your supervisor may be contacted as a character reference.

Name of Company		Position/Title
Street Address		
City/State	Zip	Date of Hire
Supervisor's Name	Supervisor's Email Address	Supervisor's Phone

Providence

SECTION E: DISCLOSURE QUESTIONS

*Please circle your answer. If you answer "YES" to any of the following questions, please provide details on additional pages and attach them to this application.

1. Have you ever been the subject of an informal or formal hearing process at any hospital?	YES NO
2. Has any professional body, either state or federal ever sanctioned you?	YES NO
3. Have you ever been convicted of, or pleaded guilty or nolo contenders, to any crime other than a minor traffic violation?	YES NO
4. Are charges pending against you for any crimes, other than a minor traffic violation, by information, indictment, or otherwise?	YES NO
5. Have you ever been under the influence of drugs and/or alcohol while in a professional capacity?	YES NO
6. Have you ever been court-martialed, investigated, sanctioned reprimanded, or cautioned by a hospital or other healthcare facility of any military agency?	YES NO
7. Have you ever been involuntarily terminated or forced to resign?	YES NO
8. Have you resigned voluntarily while under investigation or threat of sanction from a hospital or healthcare facility or any military agency?	YES NO
9. Have you ever been diagnosed with, treated for, or are currently influenced by voyeurism, pedophilia, exhibitionism, or any other sexual behavior disorder? ("Sexual behavior disorder" does not include or imply sexual preferences.)	YES NO
10. Are you currently using any chemical substance(s), legal, or illegal, that in any way impairs or limits your ability to perform your professional duties in a safe and competent manner?	YES NO

Providence

SECTION F: REQUIRED ATTACHMENTS

To this application, or as separate attachments, shadows are required to provide the following documentation:

- Government Issued ID (front and back, in color, and legible).
- Vaccination Records to include:
  - COVID-19 (a declination in place of the COVID-19 vaccination is acceptable, please see Section J for declination form if applicable).
  - Influenza (annual requirement; a declination in place of the flu shot is acceptable, please see Section I for declination form if applicable).
  - Hepatitis B, 1st, 2nd, and 3rd **OR** titer showing immunity.
  - MMR [Measles, Mumps, Rubella], 1st & 2nd **OR** titer showing immunity.
  - Varicella [chicken Pox], 1st & 2nd **OR** titer showing immunity.
  - TB, 2 non-reactive TB tests within the past 12 months **OR** negative QuantiFERON-TB Gold Blood Test within the past 12 months **OR** if positive, medical clearance including X-ray results.
  - TDAP [Tetanus, Diphtheria, and Pertussis].
- Professional Photo / Headshot

SECTION G: WRITTEN STATEMENT

In less than 200 words: how will shadowing further your interest in the medical community?

Providence

SECTION H: AKNOWLEDGEMENT

The information given or attached to this application is accurate and complete to the best of my knowledge, information, and belief. By placing my signature below, I understand that this shadowing experience is intended to be strictly observational. I understand that I am not permitted to touch patients/residents of any Providence Health & Services entity, nor handle patient/resident care equipment and/or supplies as it related to their care (this includes passing instruments). I understand that I am not permitted to discuss patient/resident conditions with patients/residents and/or their family members, nor am I to discuss what I have heard/seen and/or learned during my shadow experience with anyone outside of those appropriate persons in the Providence Health & Services system. I understand that my doing so, may constitute a HIPAA privacy violation.

Signature of Shadow: _____ Date: _____

Printed Name of Shadow: _____

PARENT/GUARDIAN SIGNATURE

* Only required if the Shadow is a minor (under 18 years of age).

I as parent or guardian of the above-named minor do hereby consent to this minor's participation in the shadow experience at Providence Alaska. I agree to the provisions as listed above and adopt it as my own and agree to reimburse Providence Alaska for any damage incurred by it for which this minor would be liable were they 18 years of age.

Signature of Parent or Guardian: _____ Date: _____

Printed Name of Parent or Guardian: _____

Providence

SECTION I: FLU DECLINATION FORM – OPTIONAL

I DO NOT WANT A FLU VACCINE. I ACKNOWLEDGE THAT I AM AWARE OF THE FOLLOWING FACTS:

- Influenza is a serious respiratory disease that kills an average of 23,607 persons and hospitalizes more than 200,000 persons in the United States each year.
- Influenza vaccination is recommended for me and all healthcare workers to protect our patients from influenza disease, its complications, and death.
- If I contract influenza, I will shed the virus for 24-48 hours before influenza symptoms appear. My shedding the virus can spread influenza disease to patients in this facility.
- If I become infected with influenza, even if symptoms are absent, minimal, or resemble a cold, I can spread severe illness to others.
- I understand that the strains of the virus that cause influenza infection change almost every year, which is why a different influenza vaccine is recommended each year.
- I understand that I cannot get influenza from the influenza vaccine.
- The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including my patients and other patients in this healthcare setting, including my coworkers, my family, and my community.
- Side effects of the vaccine are almost universally mild and of short duration.

I am declining the flu vaccine because of:

___ My licensed independent practitioner documented an allergy or medical contraindication to the components of the vaccine.

___ My religious beliefs, including my sincerely held ethical or moral beliefs.

Signature of Shadow: _____ Date: _____

Printed Name of Shadow: _____

PARENT/GUARDIAN SIGNATURE

* Only required if the Shadow is a minor (under 18 years of age).

Signature of Parent or Guardian: _____ Date: _____

Printed Name of Parent or Guardian: _____

Providence

SECTION J: COVID DECLINATION FORM – OPTIONAL

I AM DECLINING A COVID-19 VACCINE. I ACKNOWLEDGE THAT I AM AWARE OF THE FOLLOWING FACTS:

- COVID-19 can be very contagious and spreads quickly.
- COVID-19 vaccination is recommended for all healthcare workers to protect our patients from COVID-19 disease, its complications, and death.
- Although vaccinated people sometimes get infected with the virus that causes COVID-19, staying up to date on COVID-19 vaccines significantly lowers the risk of getting very sick, being hospitalized, or dying from COVID-19.
- Persons infected with COVID-19 virus, including those who are pre-symptomatic, can transmit the virus to coworkers and patients, some of whom may be at higher risk for complications from COVID-19.
- Some people are more likely than others to get very sick if they get COVID-19. This includes people who are older, are immunocompromised, have certain disabilities, or have underlying health conditions.
- COVID-19 may attack more than your lungs and respiratory system.
- Some people include those with minor or no symptoms will develop Post-COVID Conditions – also called "Long COVID."
- I cannot get COVID-19 from the vaccine and studies show that people who have antibodies from an infection with the virus that causes COVID-19 can improve their level of protection by getting vaccinated.
- The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including my patients and other patients in this healthcare setting, my coworkers, my family, and my community.
- Side effects after a COVID-19 vaccination tend to be mild, temporary, and like those experienced after routine vaccinations.
- I understand I must follow all current infection prevention policies and procedures for my location, such as masking, to limit the possibility of transmission of the virus.
- I understand that I can change my mind and agree to provide my vaccination record if I receive the vaccine in the future.

I am declining the COVID-19 vaccine because of:

___ My licensed independent practitioner documented an allergy or medical contraindication to the components of the vaccine.

___ My religious beliefs, including my sincerely held ethical or moral beliefs.

Signature of Shadow: _____ Date: _____

Printed Name of Shadow: _____

PARENT/GUARDIAN SIGNATURE

* Only required if the Shadow is a minor (under 18 years of age).

Signature of Parent or Guardian: _____ Date: _____

Printed Name of Parent or Guardian: _____

Providence

CONSENT & RELEASE FROM LIABILITY ATTESTATION

I hereby apply to participate in a shadowing experience approved by the Providence Alaska Medical Staff Services Department. In return for my application being considered, I agree to be legally bound to the following terms and conditions:

1. To the fullest extent permitted by law, I extend immunity to, release from any and all liability, and agree not to sue any of the following entities or individuals if their actions are done in good faith:
    a. Providence Alaska.
    b. Any authorized representatives of Providence Alaska.
    c. Any person providing information to or receiving from Providence Alaska, for any actions or communications relating to my application or any other professional review activity.
    d. The Board of Directors of Providence Health & Services acting as a review organization in the credentialing process.

In consideration of Providence Alaska permitting me to participate in a shadow experience, I agree:

1. I, for myself, my heirs, administrators, executors, and assignees, hereby covenant and agree that I will never institute, prosecute, or in any way aid in the institution or prosecution of any demand, claim, or suit against Providence and/or its agents or employees, acting officially or otherwise, for any loss, damage, or injury to my person or property which may occur from any cause whatsoever as a result of my participation in the activities at Providence or going to or from the facility.
2. I authorize Providence and authorized persons to share information with each other and consult with third parties regarding my competence, professional conduct, character, ethics, behavior, or other matters bearing on my qualifications.
    a. The term “authorized representatives” means any persons who have any responsibility for obtaining or revaluating my credentials, acting upon my application, or conducting professional review activity for any of the above referenced organizations, including governing body members, employees, medical staff, or committee members, consultants, and attorneys.
    b. The term “professional review activity” means any action or communication by Providence or any of the organizations or persons referenced above related to any determination as to whether I may be a shadow.

I hereby certify that:

1. I have never been convicted of any criminal felony or misdemeanor relating to the practice of my profession, or any health care related matters, third-party reimbursement, or controlled substance violations.
2. I have never been diagnosed with, treated for, or are currently inflicted with voyeurism, pedophilia, exhibitionism, or any other sexual behavior disorder.
3. I am not using any illegal drugs or any other substance that would impair my ability to perform those essential functions pertinent to my role as a shadow.

I understand and agree that I may be held liable for any damages or loss to Providence, which is caused by my negligence, willful conduct, dishonesty, or fraud.

Any misrepresentation, mistreatment, or omission from this application, whether intentional or not, is cause for the immediate cessation of the processing of this application and no further processing shall

occur, and my shadow experience will be denied. Upon subsequent discovery of such misrepresentation, misstatement, or omission, my shadow experience will be immediately ended.

I have read and fully understand the foregoing instrument and agreement to the same by affixing my signature.

Signature of Shadow: _____ Date: _____

Printed Name of Shadow: _____

PARENT/GUARDIAN SIGNATURE

* Only required if the Shadow is a minor (under 18 years of age).

I as parent or guardian of the above-named minor do hereby consent to this minor's participation in the shadow experience at Providence. I agree to the provisions as listed above and adopt it as my own and agree to reimburse Providence for any damage incurred by it for which this minor would be liable were they 18 years of age.

Signature of Parent or Guardian: _____ Date: _____

Printed Name of Parent or Guardian: _____

Providence

CONFIDENTIALITY AGREEMENT

GUIDELINES FOR PRACTICING CONFIDENTIALITY

1. Information about patients should not be discussed in a public setting, with health care workers not directly involved in their care, nor revealed to reporters, the press, or social media.
2. Medical and nursing records should not be left out at any location.
3. Patients must give permission for information (such as diagnosis) to be revealed to anyone. A patient may withdraw permission at any time. Such permission must be documented in the medical record of the patient.
4. When a patient is your neighbor or friend, you should reveal this information to your supervisor prior to seeing the patient; this is considered a conflict of interest.
5. Interviews with confused or disoriented patients are not permitted without family and/or the practitioner's permission.

I have read the guidelines above and agree to abide by them and do hereby agree to keep all information obtained regarding patients and/or practitioners confidential. I hereby agree not to discuss any information obtained during this observational experience with persons outside the facility. I release Providence Alaska and its representatives of any liability arising from a breach of confidentiality caused by myself.

Signature of Shadow: _____ Date: _____

Printed Name of Shadow: _____

PARENT/GUARDIAN SIGNATURE

* Only required if the Shadow is a minor (under 18 years of age).

I, as parent or guardian of the above-named minor do hereby consent to this minor's participation in the shadow experience at Providence. I agree to the provisions as listed above and adopt it as my own and agree to reimburse Providence for any damage incurred by it for which this minor would be liable were they 18 years of age.

Signature of Parent or Guardian: _____ Date: _____

Printed Name of Parent or Guardian: _____

SUPERVISING PRACTITIONER SIGNATURE

I, as the supervising practitioner of the above-named shadow, do hereby agree that I have read the guidelines and agree to abide by them. I hereby agree not to discuss any information obtained during this experience with the shadow unless permission has been granted by the patient and documented in the medical record of that patient. I release Providence and its representatives of any liability arising from a breach of confidentiality caused by myself.

Signature of Supervising Practitioner: _____ Date: _____

Printed Name of Supervising Practitioner: _____

Providence

SUPERVISING PRACTITIONER FORM

Name of Shadow	Dates of Shadow Experience (90-day maximum)
Name of Supervising Practitioner (Must be a member of the **ACTIVE** Medical Staff)	Supervising Practitioner's Specialty

GUIDELINES FOR STUDENT SHADOWS

- The Shadow must be referred by an appropriate source (i.e., active medical staff member, school counselor, teacher, program, etc.)
- The Shadow must work with a staff member from the Medical Staff Services Department prior to their shadow experience to review the purpose of the experience. The Shadow will receive, via email, a brief orientation, which will include general information, opportunities, and expectations.
- The Shadow is required to provide written statement releasing liability for Providence Alaska. If under 18 years of age, a signed consent from parent/legal guardian prior to shadow experience stating the release of liability for Providence and permitting the learning experience.
- The Shadow must review and sign the confidentiality agreement, HIPAA (Health Insurance Portability and Accountability Act), and met immunization requirements prior to the shadow experience.
- The Shadow while participating in this shadow experience is expected to:
    - Always wear a visitor identification badge when shadowing in a visible location.
    - Adhere to the Providence Code of Conduct Policy and maintain appropriate behavior while in the facility.
    - Adhere to Providences' mission and core values.
    - Respect patient's/resident's rights and privacy.
    - Dress in appropriate attire (no jeans permitted).
    - Only pierced ears on the lower lobe of the ear are permitted on a person. All other piercing jewelry must be removed.
    - Wear low-heeled (or no-heel), comfortable, and closed-toe shoes.
- The Shadow experience is intended to be strictly observational. Shadows are not permitted to touch patients/residents, handle patient/resident care equipment, supplies, or to hand instruments under any circumstances. Shadows are not allowed to write in a patient's chart or to discuss a patient as it related to their care. Nor may they discuss the patient's/residents' conditions with patients/residents' family or anyone else in the room.
- Permission must be granted by the patient and/or the family/guardian of the patient for the shadow to observe.

The information given in or attached to this application is accurate and complete to the best of my knowledge, information, and belief. By placing my signature below, I understand that this shadowing

experience at Providence Alaska is intended to be strictly observational. I understand and will abide by the guidelines listed above.

Signature of Shadow: _____ Date: _____

Printed Name of Shadow: _____

PARENT/GUARDIAN SIGNATURE

* Only required if the Shadow is a minor (under 18 years of age).

I as parent or guardian of the above-named minor do hereby consent to this minor's participation in the shadow experience at Providence. I agree to the provisions as listed above and adopt it as my own and agree to reimburse Providence for any damage incurred by it for which this minor would be liable were they 18 years of age.

Signature of Parent or Guardian: _____ Date: _____

Printed Name of Parent or Guardian: _____

SUPERVISING PRACTITIONER SIGNATURE

As supervising practitioner for this shadow, I will assume the responsibility for the shadow. By placing my signature below, I understand that this shadowing experience is intended to be strictly observational. I understand that the shadow is not permitted to touch patients/residents of any Providence Health & Services entity, handle patient resident care equipment and/or supplied as it related to their care (this includes passing instruments). I understand that the shadow is not permitted to discuss patient/resident conditions with anyone outside of those appropriate persons in the Providence Health & Services system. I understand that his/her doing so, may constitute a HIPAA privacy violation. I understand I have full responsibility for all actions or omissions of this shadow. I understand I am responsible for the active supervision of this shadow. Should my supervising relationship with this Shadow change, I understand I am responsible to provide written notification to the Medical Staff Services Department.

Signature of Supervising Practitioner: _____ Date: _____

Printed Name of Supervising Practitioner: _____

Providence

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

PROVIDENCE HEALTH & SERVICES

VISITOR & TEMPORARY STAFF INFORMATION

HIPAA is a federal law that was passed in August 1996. Providence Health & Services Alaska (PHSA) must comply with HIPAA and as a temporary PHSA worker or visitor who may be exposed to patient information, you are responsible for understanding and upholding this law. If you have questions or are unsure of the appropriate way to proceed, please ask the department manager or your immediate supervisor.

Protected Health Information (PHI): Information that relates to the past, present, or future physical or behavioral condition, care, or payment of a patient and which identifies or could be used to identify a patient. It includes information in any form or medial, including oral, written, or electronic.

WHAT YOU NEED TO DO:

- Access only the minimum amount of PHI needed to perform your job.
- Do not look up PHI about yourself or for family members, friends, or neighbors.
- Do not talk about patients' PHI with family members, friends, or neighbors.
- Be aware of how you handle PHI in the course of your assignments.
- Be aware of who can hear your conversations.
- Dispose of paper PHI by shredding it or by placing it in secure recycling bins.
- Dispose of electronic PHI in a manner that will render the data unrecoverable.
- Never share or post passwords.
- Log off before leaving your workstation.

PRIVACY RULE:

- Gives patients more control over their PHI.
- Sets boundaries on use and release of PHI.
- Holds violators accountable with civil/criminal penalties.
- Allows some leeway for disclosing PHI in the best interest of the public.
- Enables patients to find out how their PHI may be used and disclosed.
- Limits release of PHI to the minimum needed for the purpose of the disclosure.

Criminal and Civil Sanctions: There are federal penalties for violation of HIPAA standards. These penalties could potentially be applied to both Providence Health & Services in Alaska and you as an individual.

How to report a privacy concern: We appreciate your participation in helping us protect and keep patients PHI confidential. If you notice an area that needs improvement concerning patient confidentiality, please report it to the department manager or contact the Alaska region concern line to report issued to the Privacy Officer at 1-800-510-3375.

I will abide to these standards.

Signature of Shadow: _____ Date: _____

Printed Name of Shadow: _____

PARENT/GUARDIAN SIGNATURE

* Only required if the Shadow is a minor (under 18 years of age).

I as parent or guardian of the above-named minor do hereby consent to this minor's participation in the shadow experience at Providence. I agree to the provisions as listed above and adopt it as my own and agree to reimburse Providence for any damage incurred by it for which this minor would be liable were they 18 years of age.

Signature of Parent or Guardian: _____ Date: _____

Printed Name of Parent or Guardian: _____