



2827 Fort Missoula Road  
Missoula, MT 59804

TEL (406) 728-4100  
www.communitymed.org

From day one.

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Welcome!

Thank you for your interest in Job Shadowing at Community Medical Center. In compliance with the Joint Commission, we have prepared a packet of information to be read and a guideline of documentation that needs to be completed.

Please review, read, and initial (when required) the following documents:

- Shadowing Program Policy
- Job Shadow Professional Appearance

If you feel that you agree to the terms for job shadowing, please review, complete, initial, (when required) and return the following documents to Volunteer Services in order for you to be eligible to job shadow:

- Job Shadow Application
- HIPAA Privacy, Security and Confidentiality Agreement
- Shadowing Agreement
- Copy of 2 Tuberculosis (TB) Tests within the last 12 months (completed within 7-12 days of each other), or a Negative Quantiferon TB Test, or 1 TB test along with completed questionnaire
- Copy of Measles, Mumps & Rubella (MMR) Immunization Records (2 dates received or 1 Titer for each)
- Copy of Varicella (2 dates received or 1 Titer)
- Copy of Tetanus with Pertussis (Tdap) Immunization (1 date received within last 10 years)
- Copy of Flu Immunization (Yearly, within last 12 months)

Once all the required items listed above have been submitted to Volunteer Services, the Department manager in the area of interest you've indicated will be contacted to approve the shadowing. The Volunteer Supervisor will then contact you with the date and time that has been approved for shadowing. Response time for this process may vary depending on the department's availability and program demands.

We at Community Medical Center strive to provide a positive work environment for all of our Job Shadowers. We hope that your time with us will be an enjoyable and educational experience.

Sincerely,

Jennifer Martin,  
Volunteer Supervisor

## Shadowing Program Policy

The Shadowing Program is intended for those who have an interest in Health Care. Shadowing allows the participant to *follow* and *observe* a medical professional as they carry out their job responsibilities at Community Medical Center.

Participants must be at least 16 years of age and enrolled in related high school or college courses or be an adult who has expressed great interest in a health care career. Requirements of paperwork and immunization records must be completed and submitted to the Volunteer Supervisor. A department manager will approve the shadowing and the Volunteer Supervisor will then contact the shadowing applicant with the date and time that has been approved for shadowing. Response time for this process may vary depending on the department's availability and program demands.

The following regulations apply: Please read and initial:

- \_\_\_\_\_ CMC reserves the right to a pre-screening process to determine eligibility to participate in the shadowing program.
- \_\_\_\_\_ Shadowing is a voluntary opportunity for which there will be no monetary compensation.
- \_\_\_\_\_ Participants must be 16 years of age or older, enrolled in high school, vo-tech, home-schooling, college courses, or be an adult who has expressed interest in a career change to health care.
- \_\_\_\_\_ Participants must review and complete the Community Medical Center Job Shadow Information packet, including:
  - Job Shadow Professional Appearance
  - Job Shadow Application
  - HIPAA Privacy, Security, and Confidentiality Agreement
  - Shadowing Agreement
- \_\_\_\_\_ Completed Job Shadow Information packet and proof of immunization records must be mailed to Volunteer Services, 2827 Fort Missoula Rd, Missoula, MT 59804.
- \_\_\_\_\_ On the day of shadowing, participants will need to obtain a badge from the Front Desk. In order to obtain a badge, participants will need to leave their driver's license with the Front Desk. This badge MUST be returned to the Front Desk at the end of day, at which time the participant's driver's license will be returned.
- \_\_\_\_\_ Upon return of badge, the participant will be asked to fill out an evaluation and feedback form, regarding the experience, to help determine the effectiveness of the program.

**Time Limitations:** Under the binding agreement, a shadowing participant may shadow a team member for up to 4 hours maximum per position, not to exceed 8 hours of shadowing total.

## **Job Shadow Professional Appearance:**

Professional appearance is of primary importance when delivering or supporting patient care at Community Medical Center. We believe that appearance impacts the level of confidence that families, patients and hospital associates have in a hospital. When you have a neat appearance and appropriate attire, you convey a professional attitude of excellence that has become synonymous with Community Medical Center.

The following guidelines apply to all job shadow participants. As indicated, patient care/clinical staff (staff whose primary job involves work in a patient care area) have more specific guidelines for safety. A member of the Leadership Council may further define appropriate standards of appearance to meet particular and/or unique circumstances in their department or unit. The Leadership Council may also grant approval for deviation from the personal appearance guidelines for special events.

### **Guidelines for Professional Appearance**

#### **Pants Acceptable**

- Pressed, clean slacks that come to mid-calf or longer
- Corduroy or gabardine slacks and khaki slacks
- Dress slacks
- Undergarments must be worn

#### **Pants Unacceptable**

- Jeans of any type or color
- Sweatpants
- Shorts of any kind
- Bib overalls
- Spandex, leggings, or stretch pants
- Running pants
- Pants that are worn, torn, frayed, or faded
- Visibly skin-tight pants
- Undergarments that show through outer clothing
- Bare legs

#### **Shirts/Blouses/Jackets Acceptable**

- Collared shirts
- Blouses
- Golf or polo shirts
- Sweaters
- Turtlenecks
- Sports jackets
- Suit jackets
- Undergarments must be worn

#### **Shirts/Blouses/Jackets Unacceptable**

- Logo T-Shirts
- Sweatshirts

- Midriff-baring tops
- Tank tops or shirts that do not cover the shoulder

#### Shirts/Blouses/Jackets Unacceptable (cont.)

- Shirts that are sheer, revealing, or low-cut
- Shirts that are worn, torn, frayed, or faded
- Visibly skin-tight or backless tops
- Undergarments that show through outer clothing

#### Dresses and Skirts Acceptable

- Dresses and skirts (no more than two inches above the knee in length)

#### Dresses and Skirts Unacceptable

- Miniskirts
- Spaghetti-strap or dresses that do not cover the shoulder
- Visibly skin-tight skirts/dresses
- Skirts/dresses that are sheer, revealing, or low-cut
- Bare legs

#### \*Scrubs

- Scrubs are not to be worn. If scrubs are required, they will be provided.

#### Footwear Acceptable

- Tennis or walking shoes
- Clogs (ex: Danskos or Birkenstocks)
- Loafers or comfortable dress shoes

#### Footwear Unacceptable

- Bare feet
- Slippers
- "Flip-Flops"
- Open-toed shoes

#### Hats and/or Head coverings are not acceptable, exceptions include:

- Job required hats and/or head coverings
- Hats and/or head coverings while undergoing chemo
- Hats and/or head coverings required for religious observation

#### Hospital Identification Badge

- Badge worn above waist
- Name, picture, and/or job title are visible

#### Hospital Identification Badge Unacceptable

- Defacement of badge (ex: stickers that cover name picture or job title)

#### Jewelry Acceptable

- Two rings
- Earrings that do not dangle off the ear more than ½ inch
- One nose stud up to 2 mm in size
- Must be professional in appearance

#### Tattoos Acceptable

- Covered tattoos are preferred

**Tattoos Unacceptable**

- Visible tattoos that are perceived as offensive or inappropriate as determined by the department

**Personal Hygiene**

- Clean and neat
- Non-offensive body odor

**Nails Acceptable**

- Well-maintained
- Clear or lightly polished

**Nails Unacceptable**

- Chipped nail polish
- Decorations such as glitter, strips, etc.
- Any type of artificial nail
- Nails longer than ¼ inch

**Hair Acceptable**

- Clean and neat
- Facial hair that is well groomed

**Hair Unacceptable**

- Hair dyeing that is not a natural color (purple, blue, etc.)
- Hair longer than shoulder length that is not pulled back

**Fragrances Unacceptable**

- Cologne or perfume
- Aftershave
- Scented lotion or body spray

**Makeup Unacceptable**

- Heavy

\*\*Community Medical Center provided scrubs should not be worn or carried off the premises without your supervisor or manager's approval. You are expected to check with your supervisor about specific appearance standards for your department or unit. Any clothing and/or accessories (including jewelry) that interfere with patient care and/or your ability to effectively perform work duties are prohibited. Supervisors and/or Managers have the authority to address your appearance. If you dress inappropriately, you will be asked to leave and return in appropriate attire.

INITIAL AND DATE: \_\_\_\_\_

**Identification Badges**

The Hospital identification badge must be worn above the waist. Your identifying information must be visible at all times. The badge may not be altered or have anything affixed that would prohibit proper function. Your badge must be in your possession at all times for the purpose of time recording and identification in the case of an emergency and/or disaster. If your identification badge is lost or stolen, you must report it to the Volunteer Services department immediately. If your badge is lost, there will be a replacement charge. For additional information, refer to the Professional Appearance section of this resource guide and handbook. INITIAL AND DATE: \_\_\_\_\_

# Job Shadow Application

Name:

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First Middle Last

Address:

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City State Zip Code

Phone:

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Home Cell

Email: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security Number \_\_\_\_\_

School/Organization:

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Departments of Interest:

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Available (list times)

Monday

Tuesday

Wednesday

Thursday

Friday

What you hope to gain from your job shadowing experience:

**Please Return Completed Application to CMC Volunteer Services**

\*\*\*\*\*Office Use Only\*\*\*\*\*

Date Approved: \_\_\_\_\_ Application \_\_, HIPAA \_\_, Dress Code \_\_,  
2 TB Tests \_\_, MMR \_\_, OIG \_\_, EPLS \_\_, Badge Returned \_\_, Drivers License \_\_

Communication Log

Date  
Communication

Shadow Log

Date  
Department  
Time  
Employee

# HIPAA PRIVACY, SECURITY and CONFIDENTIALITY AGREEMENT

## Job Shadow

Name (PLEASE PRINT) \_\_\_\_\_

Information about patients, employees or volunteer staff of Community Medical Center must be treated as confidential. It is the obligation of every employee, volunteer, professional staff member or student to maintain confidentiality.

Confidential information includes (but is not limited to) patient records and patient-related information, including financial information; employee records; any information of a private or sensitive nature; or any information whose unauthorized or indiscreet disclosure could prove harmful to a patient, employee, volunteer or Community Medical Center.

PLEASE READ AND INITIAL THE FOLLOWING:

Community Medical Center requires that all job shadows must sign the following confidentiality agreement:

- \_\_\_\_\_ I will protect the confidentiality of patient and hospital information.
- \_\_\_\_\_ I will not release unauthorized information to any source.
- \_\_\_\_\_ I will not access or attempt to access information other than that information which I have been authorized.
- \_\_\_\_\_ I will not access any computers.
- \_\_\_\_\_ I will not use another person's computer security code.
- \_\_\_\_\_ I will not fax patient information outside of the hospital.
- \_\_\_\_\_ I understand that any violation on my part of the above conditions could result in immediate termination of my job shadow.

I have read and agree to adhere to the conditions of this Confidentiality Agreement.

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

**Please Return Signed HIPAA/Confidentiality Agreement to CMC Volunteer Services**



## CMC Shadowing Agreement

This Agreement reflects that Community Medical Center (CMC), in response to interest in a job shadowing program at its facility, desires to assist high school, college students or an adult with healthcare to discover whether they want to pursue a future career in the health care profession. In consideration of this, the following are conditions and terms for shadowing at our facility:

Shadowing is defined as to *follow* and *observe* a medical professional as they carry out their job responsibilities at CMC.

Participants must be at least 16 years of age and enrolled in high school or college courses or an adult who has expressed great interest in a health care career. All requirements of paperwork, TB results and MMR records must be completed and submitted to the Volunteer Supervisor (VS). A department manager will approve the shadowing and then the VS will contact you with the date and time that has been approved for shadowing. Response time for this process may vary depending on the department's availability and program demands. As a participant in the shadowing program, I understand and agree:

- I will not touch the patients. If I am allowed to observe a patient having a procedure, I understand the director or manager is to obtain the patient's consent first.
- I will not touch medical equipment.
- I do not have medical record or chart access and will not have computer access.
- I will not assist in feeding but may help deliver food.
- I will not approach physicians about personal illness or medications.
- I will dress professionally as outlined in the attached dress code.
- I agree to a health record review by CMC Employee Health Services to include proof of immunizations (MMR, Varicella, Tetanus with Pertussis, Flu, and 2 TB skin tests or chest x-ray within the past year. If a TB test has not been previously completed, I understand I will obtain this before being able to shadow).
- I am subject to CMC's drug testing policy. If I object, I will be asked to leave the premises immediately.
- I understand CMC is not held responsible for any accident or injury that may occur on its premises while shadowing. In addition, I am to leave valuables at home and realize it is my responsibility that these items are secured prior to shadowing.
- I will not perform my own personal care in the clinical setting (i.e. applying lip gloss, handling contact lenses, eating or drinking, brushing hair, etc.
- I will not be permitted in areas of contamination such as isolation rooms, soiled linen areas, lab, and autopsy room.
- I cannot participate in the program on days that I am ill as determined by Employee Health Services. It is my responsibility to report to Employee Health Services before reporting for a work assignment or with the onset of signs and symptoms consistent with illness. These include but are not limited to: fever, diarrhea, productive cough, rash, or open wound.

- I understand that I will be required to sign a HIPAA Privacy, Security, and Confidentiality Agreement wherein I agree to keep all patient information confidential.
- I understand that CMC shall have the right to immediately terminate my participation in the program if it is determined at the manger or supervisor’s discretion that I am not acting in the best interest of the patient or facility. In addition, the director or manager holds the right to terminate shadowing at any point if deemed necessary.
- Upon arrival to CMC, I will obtain a Job Shadowing Participant badge from the front desk and return it upon departure each day of shadowing. As a shadow participant, I understand my visit is limited to a four hour shift per position not to exceed eight hours total of observing a team member of Community Medical Center. Anything beyond this time must be approved by Volunteer Services. The director, manager, and/or preceptor have the right to terminate shadowing at any time the need may arise.
- I will abide by the policies of Community Medical Center and will sign the attachment statements. My electronic or written signature below certifies my understanding of the information above.

SIGNATURE \_\_\_\_\_

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_

Emergency Contact and Phone Number:  
\_\_\_\_\_

***Parental Consent if student is less than 18 years of age***

Parent Signature: \_\_\_\_\_

Parent Name and Phone Number: \_\_\_\_\_

**Please Return Signed Shadowing Agreement to CMC Volunteer Services**