Shadowing Check List
Shadowing Coordinators: Brooke Fenske & Dylan Hoyt

This is a list of all the paperwork that must be completed and submitted before you shadow a doctor at Alegent Creighton. This paperwork must be submitted to Marianne Clark in the EDGE office, by the library, where the shadowing coordinators will collect it.

Before you Shadow:

- **Shadowing Policy Agreement** signed and submitted ___
- **Contact Information** Sheet ___
- **Confidentiality Agreement** signed and submitted ___
- **Last slide of Alegent Creighton’s HIPAA** with name printed, signed, and dated. This can be found at [www.alegent.com/hipaa](http://www.alegent.com/hipaa). ___
- **Immunization record** obtained from Student Health in Harper. ___
  - All vaccinations MUST be present to shadow
    - MMR (Mumps, Measles, and Rubella)
    - Hepatitis B
    - Influenza (Must have received vaccination within the past year)
    - Pertussis (DNP/Tdap)
    - Chickenpox- Varicella Zoster, (either history of Chickenpox. Vaccination, or verification of immunity by blood test)
- **Annual PPD (TB) skin test** or documentation of a **negative Chest X-ray within the past year** ___
- **Agreement Form** signed and submitted ___

Submit a **resume** titled “LastnameFirstname.doc” to Brooke Fenske (Brookefenske@creighton.edu) and schedule a time to meet for an **interview**. The available times to interview are listed on the Pre-Medical Society Shadowing page along with instructions to schedule the interview.

After you Shadow:

- Thank the doctor before leaving the procedure and return any scrubs/materials borrowed by Alegent Creighton ___
- Thank you Letter sent to the doctor you shadowed. This is not documented and tracked by myself, but shows the doctors professionalism ___
- Email me about what you learned and observed. This does not need to be very long. Just a sentence or two would suffice **not required, but appreciated**
As a Student of Creighton University, you will represent the University during your time at Alegent Creighton. There will be zero-tolerance for any action that may compromise the integrity of the program, Creighton University, or Alegent Creighton. You will be assigned in a field of medical practice that involves sharp objects and possible bloodborne pathogens. By signing this form, you are agreeing to abide by all policies enforced by Creighton University, Alegent Creighton, and this Shadowing program. We are in no way responsible for any injury that may arise from the practice of shadowing doctors at Alegent Creighton. If an injury does occur or you feel that you have been exposed to a bodily fluid other than your own, alert the doctor you are shadowing and follow all procedures that are in place at Alegent Creighton.

The process of shadowing is limited to the direct interaction with the doctor being shadowed. You do NOT have the privilege to access other areas of the hospital without prior permission by the shadowing coordinator or the doctor being shadowed. This includes but is not limited to:

- Shadowing another doctor not assigned to you by the shadowing program
- Shadowing multiple surgeries without the consent of the patient and the doctor.
- Leaving without notifying the doctor

You, as the student shadow, will appear in a professional and neat manner. You must be punctual; being no later than fifteen minutes prior to the scheduled meeting time. You must accommodate time for travel, parking, and potentially getting lost. There is a free valet service available Monday through Friday that Alegent Creighton provides. This can be accessed at the front of the Hospital.

The doctors that you will be partnered with will validate any deviation from this agreement. If it is found that you have not complied with this agreement, are late for the scheduled surgery/procedure or have not showed up, and/or have not acted in a professional manner, you will be terminated from this program. By signing this document, you accept the terms and conditions of this program.

_______________________                      ___________________  
Student Name (Print)                                                                                                   Date

_________________________                                                         ___________________
Student Signature                                                                 Parent Signature (For those under 19 years of age)
Contact Information Sheet
Shadowing Coordinators: Brooke Fenske & Dylan Hoyt

This information will be used to contact you when the shadowing coordinator has paired you with a doctor for a scheduled surgery.

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>Age</th>
</tr>
</thead>
</table>

Gender: M / F

Class Standing: Fr So Jr Sr

(____) ______-__________
Phone Number

______________________________
Email Address

(____) ______-__________
Alternate Phone

Texting? Y / N

Preferred method of Contact: Email Text Phone

Comments:
Example student immunization record with all required immunizations as listed in the shadowing checklist above:

- Immunization record obtained from **Student Health in Harper**. ___
  - All vaccinations **MUST** be present to shadow
    - MMR (Mumps, Measles, and Rubella)
    - Hepatitis B
    - Influenza (**Must have received vaccination within the past year**)
    - Pertussis (DNP/Tdap)
    - Chickenpox - Varicella Zoster, (either history of Chickenpox. Vaccination, or verification of immunity by blood test)
  - **Annual PPD (TB) skin test or documentation of a negative Chest X-ray within the past year** ___

**Note:** If you have records of immunizations or PPD (TB) test from a medical facility other than Creighton’s Student Health, you will personally need to contact that medical facility and request an official copy of your records in order to submit to the Pre-Medical Society Shadowing Program.
Privacy Agreement

I, _________________________, understand that the information being provided to the current shadowing coordinator of Creighton University's Premed Society Club will be solely used for purposes pertaining to shadowing done at the Alegent Creighton Hospital. I am aware that the signing of this document must be completed before any shadowing is done at Alegent Creighton.

Information Agreement

I agree that the information provided about myself is accurate to the best of my knowledge. Falsifying any information will lead to the suspension of any and all shadowing positions I have available. I will also be required to stay up to date and/or receive any vaccinations that are required to shadow, along with a PPD Tuberculosis (TB) skin test or chest X-ray within twelve months of shadowing. If I have a PPD skin test or a chest X-ray that comes back positive, I will report this information to the shadowing coordinator prior to shadowing. Unless stated otherwise by Alegent Creighton, this will not necessarily deny me a shadowing opportunity.

Amendment/Revision Agreement

I understand and abide by all new amendments or revisions done to this document. The Premed Society Club’s Shadowing Coordinator reserves the right to make such changes as necessary and it is my responsibility as a student to recognize all new revisions and comply with them.

_________________________                                          _______________________
Print Name                                                              Student Signature

_________ / _____ / _____                                          ______ / ____ / ____
Date of Birth                                                        Date of Birth

Parent Signature (For those under 19 years of age)
Alegent Creighton’s HIPPA
Shadowing Coordinators: Brooke Fenske & Dylan Hoyt

Read through Alegent Creighton’s HIPPA Privacy and Information Security Policy. To do this, click on the link below and click “Begin here”

www.alegent.com/hipaa

Once you have understood the information, print the last slide of Alegent Creighton’s HIPPA and include your name printed, signed, and dated.
CONFIDENTIALITY AGREEMENT

As an employee, volunteer, student, or other person affiliated with Alegent Health, you may have access to what this agreement refers to as "Confidential Information." The purpose of this agreement is to help you understand your responsibility regarding confidential information.

Confidential information includes patient, employee, volunteer, student, financial information, and other information proprietary to Alegent Health facilities or persons. You may learn or have access to some or all of this confidential information through a computer system or through your activities at Alegent Health.

You are required to conduct yourself in a manner which is consistent with Alegent Health Policies and Procedures. By reading and signing this agreement, you agree to the following:

- I will use confidential information only as needed to perform my legitimate duties.
- I will only access confidential information for which I have a need to know.
- I will not in any way divulge, copy, release, sell, lend, review, alter, or destroy confidential information except as properly authorized within the scope of my assigned duties affiliated with Alegent Health, and will be held accountable for the misuse or wrongful disclosure thereof.
- I will not misuse confidential information or carelessly care for confidential information.
- I will report any activity by individuals whose actions compromise the confidentiality of information to either my department management or the Alegent Health Information Security Administrator.
- My obligation under this agreement will continue after termination of my employment, voluntary association, or student experience.
- At all times during my affiliation with Alegent Health, I will safeguard and retain the confidentiality of confidential information. I understand that I do not have right or ownership interest in any access, password, or other authorization to confidential information.
- I will safeguard and not disclose my password or any other authorization which allows access to confidential information.
- I will be accountable for the misuse or wrongful disclosure of confidential information obtained through the use of my sign-on and password.

I acknowledge that I understand and agree that if I should not abide by this agreement, disciplinary actions up to and including termination of my affiliation with Alegent Health, will result.

<table>
<thead>
<tr>
<th>Signature (Employee/Volunteer/Student/Person Affiliated with Alegent Health)</th>
<th>Department/Associated Business Entity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Printed Name</td>
<td>Date</td>
</tr>
<tr>
<td>Title</td>
<td>Employee ID</td>
</tr>
</tbody>
</table>