UnitedHealth Services

STUDENT SHADOW PROGRAM

United Health Services Hospitals

Wilson Medical Center

Binghamton General Hospital

United Medical Associates

United Health Services Hospitals
Employment Department
33-57 Harrison Street
Johnson City, NY 13790
607.763.6186
www.uhs.net

For Employment Department Use Only
Approved by Employment __________ Date__________
Approved by Health Office __________ Date__________
Date of Shadow Experience: ________________________
Name of Person Shadowing: ________________________

I. GOALS OF THE STUDENT SHADOW PROGRAM

- Encourage students' exploration of interest in the health care field.
- Assist students in making future career decisions.
- Increase students' understanding of how personal and professional interests potentially match the career opportunities that United Health Services Hospitals has to offer.
- Demonstrate to students that United Health Services Hospitals and United Medical Associates is a great place to work.

II. METHOD

- This program offers qualified students, in an approved academic institution, the opportunity to observe various professionals as they function within the work setting. The length of the program may vary up to, but not to exceed, a six (6) hour period.
- This is not a "hands-on" experience. It is an observation and information experience only.

III. ELIGIBILITY REQUIREMENTS

- Students must be currently enrolled in an accredited academic institution at a level of junior high school, senior high school, or college.
- Students must be in good academic standing and have endorsement for the program by an appropriate academic representative (i.e., faculty, instructor, guidance counselor).
- Students must submit a complete application including all requested health forms.

IV. APPLICATION PROCESS

- Complete the attached Shadow Program Application form.
- Indicate your department(s) or position(s) of interest in order of preference. We will make every attempt to give students their first preference; however, we cannot guarantee that the area of first preference will always be available.
- Sign the Student Confidentiality and Acknowledgement Statement. Application will not be processed without a signed Confidentiality Statement.
- Have your family physician or school physician/nurse practitioner complete the Physical Assessment form, the Immunization & Laboratory Record form and the Tuberculosis Screen form. Student must pass all health history requirements in order to participate.

- Return the application and health history forms listed above by mail, or in person, to the **United Health Services Hospitals, Employment Department, 33-57 Harrison Street, Johnson City, NY 13790.**

- Once the Employment Department representative reviews and processes your application, we will contact you to arrange the shadow experience. Incomplete applications will not be processed.

- For any questions regarding the status of your application, please call the Employment Department at (607) 763-6186.

V. ORIENTATION MATERIALS

Read the attached information regarding general hospital procedures. By signing the application, students agree to abide by these standards while participating in the Shadow Program.

VI. DRESS CODE AND SYSTEM STANDARDS OF PERFORMANCE

United Health Services Hospitals' and United Medical Associates' dress code standards and behavioral standards of performance will apply to students who come on site for this program. These standards are attached for your review. By signing the application, students agree to abide by these standards while participating in the Shadow Program.

Student Shadow Program Application Form
Note: Shadows are only 2 to 6 hours/day.

Date: ______________________________

Name: ______________________________

E-Mail: ______________________________

Address: ______________________________

____

Phone #: Home: (   ) ____________________

Cell: (   ) ____________________

School / College: ______________________________

1. **Briefly describe your career goals:** ______________________________

____

2. **Briefly describe what you hope to achieve through this shadow experience:**

____

____

3. **List dates and times of day you are available: (Must be between 8:00am to 4:30pm, Monday through Friday.)**

____

4. **List position(s) or Department(s) you wish to visit (select up to two):**
   Notes:--We are <u>not</u> able to accommodate requests to shadow: 1) Physicians; 2) in the OR; and 3) Womens & Childrens nursing units.
   --Should you be injured or require medical attention while completing the shadow experience, you will be sent to the Emergency Department and your personal insurance company will be billed.
   --At least one week is required to process information.

____

Please review and initial that you have completed the following attachments and return them with your completed application:

_____	Immunization and Laboratory Record Form	Complete and have physician sign or attach applicable records
_____	Tuberculosis Screen Form	Complete and have physician sign or attach applicable records
_____	Medical History Form	Complete and have physician sign or attach applicable records
_____	Confidentiality and Acknowledgment	Read and sign
_____	Orientation Materials	Read to ensure compliance
_____	Dress Code	Read to ensure compliance
_____	Standards of Performance	Read and sign

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Student Confidentiality and Acknowledgment Statement

In accordance with United Health Services Hospitals Administrative Policy 5.4, you are expected to treat any acquired information with the utmost confidence and respect. Access to patient/employee information is strictly on a need-to-know basis in the course of your experience. Confidential information is not to be discussed in the areas where conversations can be overheard by the public. Likewise, you are responsible for maintaining the security and confidentiality of system access and passwords. Use of an employee's system access code is considered a breach of security and confidentiality. Unauthorized acquisition or disclosure of patient/employee information is considered cause for dismissal under Human Resources Policy 5.3 Disciplinary Action Procedure. Inappropriate use of electronic email and internet use can also result in disciplinary action pursuant to Administrative Policy 3.9 Electronic Mail and Internet Use.

a) *I have read the above statement and understand that if I breech confidentiality, it may result in disciplinary action from United Health Services Hospitals and/or United Medical Associates.*

b) *I have read the enclosed UHSH Dress Code Standards and System Standards of Performance and I agree to abide by these standards while participating in the program.*

c) *I understand the purpose of the Shadow Program and agree to the terms and conditions as outlined.*

Student Signature: ____ **Date:** ________

Parent/Guardian
Signature: ____ **Date:** ________
(if under 18 yrs. old)

The above student is in good academic standing and is recommended for this program.
Faculty/Guidance
Counselor
Signature: ____ **Date:** _________

Orientation Materials

Mission Statement –

Our mission is to serve the people of our region, to improve or maintain their health, and to provide patient-centered, contemporary health services in a caring, competent and convenient manner. Services will be affordable and well organized to meet the needs of our patient and their families.

Universal Blood and Body Fluids Precautions –

Appropriate protective measures will be available. Do not empty containers, feed patients, clean up spills, empty bedpans or change bed linens.

Infection Control Practices –

Do not enter a room marked “Isolation”.

Fire, Disaster, CPR Instructions –

If there is a fire or disaster: Do not panic, remain calm, and help the department in which you are as requested.

Hand Washing Techniques –

Hand washing is extremely important to remove and prevent the direct or indirect spread of organisms. Hands should always be thoroughly washed.

Wash hands before and after you come in contact with patients.

Wash hands after handling contaminated material or equipment.

Wash hands between patients, before leaving the units, when returning to units, before and after going to the bathroom, and before and after you eat.

Adequate length of time for hand washing is 30-45 seconds.

Procedure: Remove rings and watches as dirt and bacteria may accumulate under these hard-to-reach areas.

Turn on water to a comfortable temperature and leave the water running. Stand well away from the sink, as it is considered contaminated, to prevent waste from being splashed on you.

Wet hands and use enough of the hand washing agent to supply a good lather. Apply friction to all areas of your hands (areas between fingers, around nails, palms, and top of hands).

Rinse your hands thoroughly under running water, allowing water to flow from the fingertips.

Dry hands thoroughly with paper towels. Then turn off faucet with paper towel as faucets are considered contaminated.

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IMMUNIZATION AND LABORATORY RECORD

Directions: Please take to your physician for completion and return with your application to the Employment Department. This form must be on file and approved before beginning your shadow experience.

Student Name: ____

Date of Birth: ____

The following immunizations and lab studies are required by the State Health Code of New York and by United Health Services Policy:

1.

a). Tuberculin Skin Test
1st Mantoux:
Manufacturer/Lot#__________Date__________Result__________mm x________Mm, read by______________

2nd Mantoux:
Manufacturer/Lot#__________Date__________Result__________mm x________Mm, read by______________

b). Positive Reactor to TB testing must:
Complete TB screen questionnaire (see attached)
Answer: Treatment for positive skin test________Yes________No
Drug__________Date started__________Date Completed__________

2. Measles (Rubeola) Immunity-must have one of the following:

a). Date of Rubeola titer__________and results__________. **A copy of the lab report must be attached to this form.**

b). Dates for two (2) doses of live virus Measles vaccine. The first dose must be administered on or after age 12 months, the second dose must be administered more than 30 days after the first dose and after age 15 months.

Measles (1)________________ (2)________________
OR
MMR (1)________________ (2)________________
OR
Physician proof of disease (Date)____________________

TUBERCULOSIS SCREEN

Student Name: ____

PPD History: ____

1. Do you have or have you had any of the following: (Check box)

	YES	NO
Chronic Renal Failure		
Immunosuppression		
Diabetes Mellitus		
Blood/lymph disease such as Leukemia or Hodgkins or Cancer		
Silicosis		
Gastrectomy		
Jejunoileal Bypass		

2. Do you take corticosteroids (prednisone, cortisone)? ____Yes____No
   If "yes", please explain____

3. Are you taking any immunosuppressive drugs? ____Yes____No
   (Azathioprine, Cyclosporine, muromonab)
   If "yes" please explain____

4. Do you have any of the following symptoms? If "yes", please explain.

   Fever (unexplained, persisting more than 2 weeks)__________________________________

   Night sweats (for more than 2 weeks)____

   Unexplained weight loss (5lbs)____

   Cough (persisting longer than 3 weeks) ____

   Blood-tinged sputum anytime____

Physician Signature: ____Date:__________

Parent/Guardian: ____Date:__________
(if under 18 yrs. of age)

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MEDICAL HISTORY FORM

Name: ____

DOB:__________________ SSN:____________________

Address:____

Home Phone # ______________________

Height:__________ Weight:__________ Pulse:__________ Blood Pressure:____________

GENERAL EXAMINATION

Place and (X) if normal and a (+) if abnormal, and give details below

	Head-Neck		Thyroid		Hips
	Nose/Sinuses		Skin/Scars		Knees
	Teeth/Gums		Lungs		Ankles
	Eyes		Heart		Neurological
	Ears		Abdomen		Spine Functional Motion
	Mouth/Throat		Hernia		Spine Anatomical Configuration
	Glands		Varicosities		Breast (Optional)

Please comment on items checked above: ____

____

____

Have you ever had problems with any of the following? (Please circle "yes" items below)

Anemia	Dizzy Spells	Hepatitis	Rheumatism/Arthritis
Asthma	Double Vision	High Blood Pressure	Severe Headaches
Back Injury	Ear Surgery	Jaundice	Shortness of Breath
Back Pain on Lifting	Emphysema	Kidney Trouble	Sinusitis
Back Surgery	Exposed to Radioactivity	Knee Surgery	Stomach Ulcers
Back Trouble	Fainting Spells	Liver Trouble	Swelling of Ankles
Bladder Trouble	Fits/convulsions	Malaria	Swollen Joints

Bleeding Disorder	Fracture of Bone	Migraines	Thyroid/Goiter
Blood in Urine	Frequent Bowel Trouble	Nervous Spells	Tightness of Chest
Bronchitis	Frequent Nausea	Numb Feet/Hands	Tuberculosis
Cancer	Gall Bladder Trouble	Paralysis	Urination Difficulties
Coughing up Blood	Glaucoma	Pneumonia	Varicose Veins
Dermatitis	Hay Fever	Radiation Therapy	Weight Loss
Diabetes/Sugar in Urine	Heart Attack	Reaction to Chemicals	
Difficulty Hearing	Heart Disease	Reactions to Oils	
Dislocated Shoulder	Hernia	Rheumatic Fever	

Please comment on items circled above: ____

____

____

Are you allergic to Latex? Y N

Allergic to Medications? Y N

List all allergies to medications: ____

____

____

Physical Recommendation:

The individual ( ) has ( ) has not successfully completed the examination.

Date of Examination: ____

Signature of Examining Physician: ____________________________________

Printed Name of Examining Physician: _________________________________

Address of Examining Physician: _____________________________________

____

Phone Number: ____

UnitedHealth Services

DRESS CODE STANDARDS

PLEASE POST

As UHS employees we want to present an image that reflects our commitment to quality care. Appropriate dress and appearance adds considerably to each patient's feeling of confidence and well being in the care they receive. Below are our Dress Code Standards that will assist us in presenting a professional image to the community that we serve.

1. Careful attention to good grooming and personal hygiene is expected. Daily hygiene must include clean teeth, fresh breath, clean hair, clean clothes and body, and the use of deodorant.

2. Employees must wear their identification badges at all times while on duty, picture-side visible and worn chest level or higher. Name, title, license/certification and picture must be visible. No pins may be on the badge. Only employer sanctioned lanyards can be worn.

3. Fingernails must be conservative in length, not to extend 1/4 inch beyond the finger, neatly manicured and clean.
   - Artificial fingernails can not be worn by employees who have direct or indirect patient contact. Artificial nails can also be defined as an application of a product to the nail including, but not limited to, acrylic, overlay, tips, or silk wraps, nail extenders, sculptured, appliqués or gels.
   - If nail polish is used, it may not be black or fluorescent. Pastel colors are acceptable.
   - All fingernails must be solid in color and the same color (French manicure is acceptable).

4. Cosmetics and fragrances worn at work should be used with moderation by employees and should not be applied in work areas. Employees should be aware of the potential allergic reactions to cosmetics/fragrances by patients and other employees. Department managers/supervisors may require employees to eliminate/reduce their usage, based upon complaints.

5. Hair should be neatly groomed and well controlled.
   - Extremes in style are generally not acceptable (such as Mohawks, and spiked haircuts).
   - Hair should not interfere with patient care activities or safe work routines.
   - Hair may not be dyed unnatural colors (such as blue, green, and purple).
   - Beards, mustaches, goatees and sideburns are acceptable as long as they are clean and neatly trimmed.

6. Personal jewelry is permitted as long as it poses no danger to self, patients, staff or instrumentation. No facial or oral jewelry is allowed, i.e., large hooped/dangling earrings, ear disks/bars, tongue/lip piercing. An eyebrow clear spacer is allowed. Stud on the side of the nose is allowed as long as it is no bigger than ¼ inch.

7. Any Tattoos/Brands/Decorative Body Art which are obscene, or advocate sexual, racial, ethnic, or religious discrimination on any body part which is exposed must be covered during work hours. Any visible body art which is larger than 2" x 2" must be covered.

8. The certain types of footwear allowed to be worn are determined by Safety and Infection Control concerns.
   - Socks or stockings must be worn at all times if work is predominantly in a clinical setting.
   - Open-toed footwear without socks or stockings may be permissible depending on infection control and safety issues. However, flip-flops, thongs, or any shoe where a toe is separated from the rest of the toes by a shoe strap are not permitted. Footwear must be non-permeable to body fluids or other liquids.
   - Heels should be no higher than three inches and in good condition.
   - Sneakers are permissible when the nature of the job requires prolonged standing or walking.
   - Both sneakers and laces must be clean and in good condition.
   - The color of footwear must be conservative.

9. When any kind of garment is worn over uniforms, cleanliness, appearance, safety and infection control must be the primary concerns. In areas where scrubs are worn as a requirement, lab coats must be worn over scrubs outside the immediate work area. Isolation or patient gowns are not to be used in place of lab coats or jackets.

10. Extremes in apparel and grooming may be fashionable, but do not lend to a professional image and may create a safety hazard, therefore the following are considered unprofessional and are not permissible:
    - Skirts too short (those skirt lengths that are not in the proximity of the knee) or too long (below the ankle).
    - Tight fitting clothing (Spandex, Lycra) and too loose fitting clothing (oversized pants and shirts).
    - Gaudy loud colors.
    - Blue denim jeans and jackets.
    - Shorts, sweat pants, sweat shirts, and leggings.
    - Capri pants are permitted if the outfit is professional and business-like in appearance. (Capri style pants are not permitted in the Patient Care or Clinical Areas).
    - Spaghetti straps, tube tops, tank tops and strapless garments.
    - Clothing that exposes the bare midriff.

11. Under garments must be worn and should not be visible under clothing, e.g., bikini pants, hipsters, patterns or bright colors.

12. Tee shirts are not allowed as over garments. If worn as undergarments, writing, symbols or pictures cannot be visible. With prior department management approval, Hospital/Department sponsored Tee Shirts are permitted.

13. Work issued caps are allowed depending on job assignment and location. Hard hats are to be worn dependent on OSHA regulations. The following are considered unprofessional and are not permissible:
    - Do-rags, Buffs and Bandanas.

14. If department uniforms are required or allowed, they may be white, colored or prints. Department managers may recommend color coding in their area of responsibility.

15. There will be no casual days. For special events, exceptions may be allowed with prior management approval.

***** Accommodations will be made for employees with medical conditions, cultural and/or religious beliefs that require exemptions or exclusions to the above standards.***

Revised 09/04/09

UnitedHealth Services

System Standards of Performance

These Standards represent a commitment to building and maintaining a culture which enables all United Health Services' member organizations to be "**a great place to work, a great place to practice medicine, and a great place to receive care**."

ATTITUDE

I will be courteous. I will greet everyone with a smile to make them feel welcome. I will always use "please" and "thank you." I will demonstrate a "can-do" positive attitude. I will not be cynical or pessimistic.

TEAMWORK

I will set an example of cooperation in the workplace by helping, appreciating, and praising others. I will avoid disagreeing with others in front of patients/customers except when patient care would be compromised, and then I will only disagree in a professional manner. I will never blame others.

ACCOUNTABILITY

I will be responsible. "It's not my job" does not exist. If I am unable to meet a request, I will find someone who can. I will be responsible for the words I speak, the actions I take, and the promises I make.

COMMUNICATION

I will listen to patients/customers and co-workers attentively. I will use "key words for key moments" with appropriate tone and body language.

RESPONSIVENESS

I will respond to patients/customers, tasks and co-workers enthusiastically and promptly. I will keep all patients/ customers and co-workers informed.

APPEARANCE

I will follow the dress code and wear my employee ID badge visibly at all times. I will do my part to maintain a clean and safe environment.

CONFIDENTIALITY

I will observe the policies for keeping patient/customer and employee information confidential inside and outside the workplace. I will respect and protect patient/customer and employee privacy to ensure a trustworthy environment.

OWNERSHIP

I will take pride in being a United Health Services employee by publicly promoting all United Health Services member organizations. I will show enthusiasm for making United Health Services a great place to work and a great place to receive care by understanding how I can make a difference.

My Commitment to Excellence

If employed by the United Health Services, I will be committed to our Mission, Vision, Values, and Standards of Performance, and to making our organization a great place to work and a great place to receive care.

If employed, I am expected to support and commit to these Standards in my day-to-day behavior and performance and I will be held accountable for these Standards in my own interactions with patients, customers and co-workers. I acknowledge that my own performance will be evaluated based on these Standards.

I have read, understood, and agree to abide by the *"System Standards of Performance"*.

Print Name: ______________________________

Signature: ______________________________

Date: ______________________________

Revised 12/03/09