KentuckyOne Health

KYOne Health Job Shadower Consent and Release of Liability Form

My shadowing experience is to be performed from (date) _____ during the hours of _____ to _____.

I understand that my shadowing experience will potentially expose me to communicable and infectious disease, injury from needles and other sharp articles, slips and falls and other unforeseen incidents.

I understand that if I am injured or exposed to communicable disease, or suspected of being injured or exposed to communicable disease, I will be offered treatment according to KentuckyOne Health policy for such exposures and injuries. I will be held responsible for the medical expenses related to all treatment that is provided to me in such instances.

Health Status Verification

I attest to the following:

I am immune to normal childhood diseases including rubella (German measles), rubeola (measles), and varicella (chicken pox) either by natural means (diagnosed, documented, and signed by licensed healthcare provider), immunity by laboratory results (positive titre), or from vaccination (signed by licensed nurse or healthcare provider). These immunities are documented and will be presented if requested to the site supervisor for purposes of audit, regulatory survey, and/or as part of epidemiologic investigation related to communicable disease exposure.

I am free of significant eye, skin, respiratory, gastrointestinal, or other communicable infections. This includes fever, cough, cold, cold sores, hepatitis A, lice, scabies, diarrhea or recent exposure to communicable infections such as chicken pox (varicella), pertussis (whooping cough), or Tuberculosis (TB).

I am free of any skin rashes, including any reaction to recent chicken pox vaccination.

I understand that if I become sick (including but not limited to fever, cough, diarrhea, vomiting, cold or flu), I will remove myself from any hospital assignment, seek medical care as appropriate and will not return with any communicable disease.

Other Infection Control Instructions:

I must comply with hand hygiene procedures by using soap and water/hand sanitizers before and after entering any patient room or treatment area, eating, and after using the restroom.

I hereby release this facility, its employees, its agents and its medical staff and agree to hold them harmless from any and all actions and claims, not caused by their negligence, arising out of their good faith performance under this consent document.

Unpaid Experience:

My signature acknowledges that my shadowing/observation does not constitute an implied promise of future employment and I understand that this shadowing/observation experience is unpaid. I have read this form carefully before signing it, as well as the KentuckyOne Health Expectations for shadowing experiences, and have been given the opportunity to ask questions relating to my shadowing/observation experience.

Shadower Name (print)	Signature	Date
(If < 18 yrs old) Parent/Guardian Name	Signature	Date
Sponsor Name	Signature	Date