King County Medical Society

Student Shadowing / Observation Application

Step 1: Student's Biographical Information

University Name and Expected Graduation Date: _____

Anticipated Start date of Shadowing: _____

Your Name: _____

Your Email: _____

Your Address (Street, City, State & Zip): _____

_____

Are you 18 years of age or older? Yes ☐ No ☐

Are you currently serving or have served in the US Armed Forces? Yes ☐ No ☐

If yes, which sector: _____

Ethnicity:
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Other: _____
- ☐ Prefer not to answer

Have you ever been convicted of a felony? Yes ☐ No ☐

If yes, please explain the circumstances:

Read and sign below:

- I understand the observational activity provided is done as a public service in the interest of medical education.
- I understand that the observational activity does not permit photography by the observer.
- I understand that all information about patients, whether it is medical or personal, is absolutely confidential. I have read and signed the attached confidential acknowledgement form.
- I understand that as an observer, regardless of background and training, I may not perform any medical procedures. I will not have direct contact with patients, nor have unsupervised access to patients.

- I agree to the following statements:
    - My required immunizations are current.
    - I have not had any exposure to measles, rubella, or chickenpox in the last 30 days.
- I agree to hold harmless King County Medical Society from any present and future liability and/or damages for injuries arising from or growing out of this observational experience.
- I understand that under no circumstances will I solicit or distribute the information of the physicians apart of the King County Medical Society's Student Shadowing Program.

_____

Applicant's Signature Date

Step 2: Confidentiality Agreement

Read and sign below:

This practice has a legal and ethical responsibility to safeguard the privacy of all patients and protect the confidentiality of their Protected Health Information (PHI). Strong federal and state laws govern the privacy of our patients and their health information.

When you participate in shadowing experience at our practice, you are involved in a unique experience. You will be accompanying a healthcare professional for a specified period in a healthcare facility. During this time, you will or may be seeing patients with a variety of medical issues and/or you may see, hear, or have access to confidential information relating to these patients. This relates to information past, present and future.

As a condition of participating in this shadowing experience, I understand and agree that:

- I must maintain and safeguard the confidentiality of any and all protected health information.
- I will not access, use or disclose protected health information unless specifically approved as part of my shadowing experience. I will maintain all protected health information in the strictest confidence and will not disclose or allow access to protected health information to others.
- If I fail to comply with the above confidentiality guidelines, or if I breach patient confidentiality, this agreement will be terminated and my ability to participate in future activities at _____ may be terminated.
- I understand that it is my responsibility to protect patient information, confidential information, restricted information, and/or proprietary information **even after the end date of this shadowing activity**. It is unlawful to use or disclose patient information, confidential information, restricted information, and/or proprietary information for any unauthorized purpose.

_____

Applicant's Signature Date

Step 3: Letter of Intent

Type a 100 – 250 word letter of intent, explaining why you are interested in observing, and what you hope to gain from this experience, and what specialties you are hoping to observe and attach it to this application.

Step 4: Attach Resume to final application (limit to one page).

Please provide a copy of you updated resume.

Step 5: Copy of Unofficial transcript

Please provide a copy of your unofficial transcript from your school/university to show proof of enrolment.

Step 6: Immunization History

Gather documentation of your immunity to each item on the checklist below and attach it to this packet. *Note that self-reported vaccine history is not acceptable as proof of immunity.*

- **Rubeloa and Mumps** – Record of two vaccines spaced at least thirty (30) days apart, administered after one (1) year of age, positive titers or physician documented disease history.
- **Rubella** – Record of a single vaccine administered after one (1) year of age, positive titers or physician documented disease history.
- **Varicella** – Record of two (2) vaccines spaced at least thirty (30) days apart, administered after one of age, positive titers or disease history.
- **Tetanus, Diptheria and Pertussis** – Record of a single dose of Tdap vaccine within the past ten (10) years. DTap/DTP/Td are not equivalent or interchangeable.
- **Influenza** – Received annually.
- **Tuberculosis** – Record of a single TB skin test placed within one year of your observation date.

If you have a history of a positive TB skin test, submit any available supporting documentation, such as a positive TB skin test reading and chest x-ray results.