This four page application is for a college or high school Student Experience learning session (not a clinical rotation session). Please complete electronically. Incomplete applications will not be considered.

**\*Complete Non-Employed General Orientation for CHI Health link below.**

<https://rise.articulate.com/share/2PoYvUM6hHQwgNgJwEf5DlwXxtOkykA4#/>

copy and paste link into Google Chrome Browser

**Student Information**

|  |  |  |
| --- | --- | --- |
| Date: |  | |
| First Name: |  | |
| Middle Name: |  | |
| Last Name: |  | |
| Email Address: |  | |
| City: |  | |
| State: |  | |
| Zip Code: |  | |
| Cell Phone: |  | |
| Gender: |  | |
| Date of Birth (mm/dd/yyyy): |  | |
| Age: |  | |
| Employed at CHI Health? | Yes | No |
| Volunteering at CHI Health? | Yes | No |

**College or High School Information**

|  |  |  |  |
| --- | --- | --- | --- |
| College/University or High School: |  | | |
| Degree Program Enrolled: |  | | |
| Grade Level: |  | | |
| Anticipated Graduation Date: |  | | |
|  |  | | |
| Is this Student Experience learning session required by your college or High School? | | Yes | No |
| Is documentation confirming completion of the Student Experience learning session required by your college or High School? **\*\*** | | Yes | No |
|  | |  |  |
| **\*\***Complete the following if documentation is required. | |  |  |
| College or High School Faculty Name: |  | | |
| College or High School Faculty Email: |  | | |
| College Faculty Phone: |  | | |

**Student Experience Preferences:**

|  |  |
| --- | --- |
| Name of staff person you would like to shadow (if known): |  |

**Preferred Date & Time** (please allow 10 days for processing application):

|  |  |  |  |
| --- | --- | --- | --- |
| Date – 1st choice: |  | Morning (4hrs) | Afternoon (4hrs) |
| Date – 2nd choice |  | Morning (4hrs) | Afternoon (4hrs) |
| Date – 3rd choice |  | Morning (4hrs) | Afternoon (4hrs) |
| Please indicate number of hours needed to complete Student Experience: \_\_\_\_\_\_\_\_\_\_hours | | | |

**Preferred Location & Departments of Interest (list 1st, 2nd and 3rd choice):**

|  |  |
| --- | --- |
| Location choice: (list 1st, 2nd and 3rd choice below): |  |
|  | CHI Health Creighton University Medical Center, Bergan Mercy Omaha, NE - Ginger Noel, [ginger.noel@commonspirit.org](mailto:ginger.noel@commonspirit.org); Phone (O): (402) 398-6272 |
|  | CHI Health Good Samaritan, Kearney, NE  Lindsy Zechmann  [lindsy.zechmann@commonspirit.org](mailto:lindsy.zechmann@commonspirit.org)  Phone (O) 308.865.7150 |
|  | CHI Health Immanuel - Omaha, NE   1. [Lynnette Zepeda NE-Omaha](mailto:lynnette.zepeda@commonspirit.org) 402-572-3716 2. [HR\_Immanuel@commonspirit.org](mailto:HR_Immanuel@commonspirit.org) |
|  | CHI Health Lakeside - Omaha, NE - Stephanie Harrington, [stephanie.harrington@commonspirit.org](mailto:stephanie.harrington@commonspirit.org) phone 402-758-5061 |
|  | CHI Health Mercy - Corning, IA  Lara Crill [lara.crill@commonspirit.org](mailto:lara.crill@commonspirit.org) phone 641-322-6285 |
|  | CHI Health Mercy - Council Bluffs, IA  Lisa Gronstal [lisa.gronstal@chihealth.com](mailto:lisa.gronstal@chihealth.com) (712)328-5394 |
|  | CHI Health Midlands - Papillion, NE -Stephanie Harrington, [stephanie.harrington@commonspirit.org](mailto:stephanie.harrington@commonspirit.org) phone 402-758-5061 |
|  | CHI Health Missouri Valley - Missouri Valley, IA  Susan Walski [susan.walski@commonspirit.org](mailto:susan.walski@commonspirit.org) phone 712-642-9269 |
|  | CHI Health Nebraska Heart – Lincoln, NE  Becca Eckert, [rebecca.eckert@commonspirit.org](mailto:rebecca.eckert@commonspirit.org) phone 402.328.3061 |
|  | CHI Health Plainview - Plainview, NE  Diane Blair [diane.blair@commonspirit.org](mailto:diane.blair@commonspirit.org) phone 402-582-4245 |
|  | CHI Health Schuyler - Schuyler, NE Claudia Lanuza [claudia.lanuza@commonspirit.org](mailto:claudia.lanuza@commonspirit.org) phone 402-352-4075 |
|  | CHI Health St. Elizabeth - Lincoln, NE  Spencer Neill, [spencer.neill@commonspirit.org](mailto:spencer.neill@commonspirit.org) phone 402.219.5106 |
|  | CHI Health St. Francis – Grand Island, NE jennifer.hohlen@commonspirit.org phone: office 308-398-8960 |
|  | CHI Health St. Mary's – Nebraska City, NE  Donnette Hoyle [donnette.hoyle@commonspirit.org](mailto:donnette.hoyle@commonspirit.org) phone 402-873-8902 |
|  | CHI Health Clinic – Omaha Metro area (must specify location of the clinic) Amanda Peck [amanda.peck@commonspirit.org](mailto:amanda.peck@commonspirit.org) phone: 402-717-1845 |
|  | CHI Health Clinic – Lincoln, NE (must specify location of the clinic) Amanda Peck [amanda.peck@commonspirit.org](mailto:amanda.peck@commonspirit.org) phone: 402-717-1845 |
|  | CHI Health McAuley - Omaha, NE - Amanda Peck [amanda.peck@commonspirit.org](mailto:amanda.peck@commonspirit.org) phone: 402-717-1845 |
|  | CHI Health Service Center - Omaha, NE -Amanda Peck [amanda.peck@commonspirit.org](mailto:amanda.peck@commonspirit.org) phone: 402-717-1845 |

**Participant Agreement:**

As a participant in the CHI Health Student Experience program:

1. I understand the importance of maintaining the privacy of all confidential medical information.
2. I agree to maintain patient confidentiality.
3. I recognize that I may be exposed to potential risks as a result of this activity and will not hold CHI Health liable for any risks as a result of this activity.
4. 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.
5. I will not touch medical equipment.
6. I understand that I do not have medical record or chart access and will not have computer access.
7. I will not assist in feeding but may help deliver food.
8. I will not approach physicians about personal illness or medications.
9. I will dress professionally as outlined in the Dress and Grooming Standards.
10. I am subject to CHI Health drug testing policy. If I object, I will be asked to leave the premises immediately.
11. I understand CHI Health is not held responsible for any accident or injury that may occur on its premises while shadowing.
12. I understand that I am to leave all valuables at home.
13. I understand that any use of a cellular device is prohibited.
14. 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.)
15. I will not be permitted in areas of contamination such as isolation rooms, soiled linen areas, neonatal intensive care, burn unit, behavioral and autopsy room.
16. I understand that I cannot participate in the program on days that I am ill. These include but are not limited to: fever, diarrhea, productive cough, rash, or open wound.
17. I understand that I am required to complete the online General Orientation \*link above to CHI before participating in the student experience.
18. I understand that CHI Health will have the right to immediately terminate my participation in the Student Experience 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.

**Student Experience Participant Agreement:**

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| --- | --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *Name* | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *Signature Date* |

**Consent for Emergency Treatment:**

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| --- | --- |
| In the case of an injury while participating in career exploration activities at CHI Health, I give my consent for CHI Health, its physicians, employees and agents to render emergency and other necessary medical treatment.  I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(*Name),* release CHI Health, its physicians, employees and agents from any costs associated with rending of treatment to the minor that is necessary in an emergency. | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *Signature* | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *Date* |
|  |  |
| Emergency Contact Information |  |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
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**Parental/Guardian Participation Consent:**

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| --- | --- |
| If is younger than 19, a parent or guardian’s signature is required.  (Name) has my permission to participate in the Student Experience offered by CHI Health. I have reviewed the terms of this confidentiality agreement with my child, stressing the importance of maintaining the privacy of all confidential medical information he/she may encounter during the course of his/her Student Experience. I recognize that Student Experience offers a significant benefit to my child in terms of first-hand exposure to potential career opportunities in the medical field. In consideration for this benefit, I agree to hold harmless and indemnify CHI Health from any liability arising from my child’s failure to abide by CHI Health’s policies concerning the privacy of confidential medical information. | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *Signature of Parent/Guardian* | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *Date* |

Send completed applications to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Insert Location Name and Address)

Attention: Volunteer Services Coordinator