Marianjoy Rehabilitation Hospital
part of Northwestern Medicine®

OBSERVATIONAL LEARNING (JOB SHADOW) AGREEMENT

(Observation Only – "No Hands On")

Participant Name (PLEASE PRINT) _____

Participant Address _____

City _____ State _____ Zip Code _____

Participant Phone Number(s) _____

Participant E-mail _____

Participant School/Organization _____

Program of Study _____ Grade Level _____

I am currently employed, or have been employed in the past by Marianjoy Rehabilitation Hospital ☐Yes ☐ No

If yes, please specify location and position _____

Are you at least 16 years of age? ☐Yes ☐ No _____

Date of Requested Observational Learning (Job Shadow) _____

Specific department or occupation you would like to observe _____

Objective/Reason for this observational learning request

☐ This job shadow has already been arranged with: _____

☐ Please arrange this observational learning (job shadow) experience for me

Specific name of staff member you'd like to shadow (if known _____

Agreement

To encourage interest in health care professions and initiate training of future health care professionals, Marianjoy Rehabilitation Hospital on its own behalf and on behalf of its subsidiaries, affiliates and those entities of which it is a Member has agreed to allow the above-named participant ("You") to shadow professionals at the above-named provider (the "Provider"). In consideration of Marianjoy and the Provider allowing You the opportunity to participate in the observational learning (job shadow) program at the Provider (the "Observational Learning (Job Shadow) Program"), You, Marianjoy and the Provider agree as follows:

Health Requirements:

You **shall not be permitted** to job shadow in a clinical area until you provide a same day medical documentation that will be sent upon confirmation of your scheduled experience.

Confidentiality:

Any information or knowledge acquired or received by You during the course of the Observational Learning (Job Shadow) Program, including but not limited to patient case information and information contained in patient care records, shall be treated as confidential by You and shall not, unless required by law or otherwise permitted in writing by Marianjoy Rehabilitation Hospital or the Provider, be disclosed or used by You during or after Your Observational Learning (Job Shadow) Program participation.

Indemnification:

You shall release, indemnify and hold harmless Marianjoy Rehabilitation Hospital and the Provider, their members, directors, officers, employees, agents and representatives, from and against any and all responsibility and obligation for your participation in the Observational Learning (Job Shadow) Program. You agree not to hold Marianjoy Rehabilitation Hospital or the Provider liable for any or all injuries, losses damages or expenses which may occur as a result of any act or omission of Marianjoy Rehabilitation Hospital or Provider, or their members, directors, officers, employees, agents or representatives, or which may arise from Your participation in the Observational Learning (Job Shadow) Program.

Illness:

You shall forever release from liability and shall discharge all claims and causes of action, present and future, against Marianjoy Rehabilitation Hospital or the Provider, their directors, officers, employees, agents and representatives, related to or arising out of any illness, disease, injury or health condition that You may contract, develop, receive, or come into contact with while You are participating in the Observational Learning (Job Shadow) Program.

Medical Treatment:

If you become ill or are injured on the Provider's premises during the Observational Learning (Job Shadow) Program experience, the Provider will provide You with emergency medical care. You will bear the costs of any such care; in no circumstances, shall Marianjoy Rehabilitation Hospital or the Provider bear the cost of such care.

Hospital Policy:

You agree to conform to and comply with all of the Provider's policies and procedures, including those relating to safety, patient care and non-discrimination. The Provider will supply you with identification, which You shall wear at all times during the Observational Learning (Job Shadow) Program.

Term:

Your participation in the Observational Learning (Job Shadow) Program shall take place on the dates set forth above. Notwithstanding the foregoing, the Provider may terminate your participation in the Job Shadow Program at any time, without disclosing the reason for such termination to you.

IN WITNESS, WHEREOF, the parties have executed this Observational Learning (Job Shadow) Program Agreement effective as of the date written above.

PARTICIPANT SIGNATURE	DATE
PARENT/GUARDIAN SIGNATURE (REQUIRED IF PARTICIPANT IS UNDER AGE 18)	DATE