



Shadow a Nurse Program at Grady Health System

“Grady Nurses: Making a Difference Every Day”

Application (Appendix A)

Name:		
Address:		
City:	State:	ZIP Code:
Contact #:	Cell #:	Home #:
Email:		
Name of School/University:		
City\State:	Phone #:	
Expected Date of Graduation:		
Clinical Area of Interest:		
Reason for Shadowing a Nurse:		
Dates Available:		
If under the age of 18:		
Parent\Guardian Name:		
Home #:	Cell #:	Office #:
Email Address:		

Area Approved:	Date(s):
Preceptor Assigned:	

Agreement for Nurse Shadowing

I am requesting the approval to shadow a nurse at Grady Health System. I, _____, understand that a shadowing experience allows for an educational process to occur in the clinical setting. However, it does not allow the observer to participate in activities which involve the touching of patients, writing on the medical record, or answering questions posed by patients/family members, or other care-providing staff regarding the care or treatment of patients.

- Approved**
- Denied, Reason:** _____

Fax this form to 404-616-9639 or e-mail to tsummers@gmh.edu



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Release and Waiver of Liability (Appendix B)

I, _____, wish to observe the activities of a Registered Nurse at Grady Hospital System in furtherance of my educational\Career goals.

I understand that I will not be allowed to perform any clinical activities or other work, to include the touching of any patients, documenting on any medical record, and advising or providing care to any patient or family. I further understand that I will be under the supervision of a Registered Nurse. I understand that I am not to be in any patient care area without the Registered Nurse being present with me. I understand that if I breach this agreement, it will result in immediate termination of my observership.

I understand that even though I will only be observing activities on _____, I may be exposed to certain risk of bodily injury and other dangers, including but not limited to, exposure to blood born pathogens, biological waste, and dangerous chemicals. I am aware of these risks and voluntarily assume these risks.

For and in consideration of Grady Health System allowing me to observe the activities of the Registered Nurse to further my educational/career goals, I hereby release and forever discharge Grady Health System and its officers, agents and employees from all claims, demands rights and causes of action of whatever kind or nature arising from and by reason of any and all known and unknown, foreseen and unforeseen bodily and personal injuries, death or damage to property arising out of my observation activities, including but not limited to, those specific risk enumerated above.

I have read this document carefully and I voluntarily choose to participate in the activities described herein. I hereby certify that I am at least 18 years of age, I am legally competent, and I am signing this document with full knowledge of its significance.

Shadow a Nurse Applicant over 18 years of age

Date

I _____ am that parent/legal guardian of this applicant (less than 18 years of age) and agree to the terms as stated above.

Shadow a Nurse Applicant Parent/Guardian (<18 years old)

Date

Shadow a Nurse Applicant

Date



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**Confidentially and Non-Disclosure Statement
(Appendix C)**

I, _____, the Shadow a Nurse participant visiting Grady Health System, am aware of the Hospital's Regulations and policies that are issued under the Health Insurance Portability and Accountability Act of 1996 (also known as HIPAA Privacy Rule).

I understand that all patient information, including medical records, other medical information, billing and financial data, is confidential.

I agree to keep all patient information confidential.

I agree to comply with all Hospital Privacy Policies and Procedures including those implementing the HIPAA Privacy Rule.

I understand that if I violate patient confidentiality by using or disclosing patient information improperly, I may be subject to disciplinary action including having my observership terminated.

I understand that if I have any questions or concerns about the Privacy Rule and/or the proper use or disclosure of patient information, I shall ask my Preceptor, Program Coordinator, Clinical Director of the area, Hospital Privacy Officer or Hospital Compliance Officer.

I understand and agree that the Hospital Privacy Policies and procedures will apply to any and all patient information even after my observership has been completed.

SIGNATURE Shadow a Nurse Applicant

Date

SIGNATURE Parent/Legal Guardian if <18 years old

Date

SIGNATURE Shadow a Nurse Program Coordinator

Date