Dear Prospective Cardiac Sonography Applicant,

Thank you for your interest in the Cardiac Sonography Program. We are happy to have you observe within the cardiac sonography departments of Ascension St. Vincent to further educate you on what a sonographer does on a daily basis. The field of sonography encompasses many different concentrations and you will have the opportunity to experience that during this observation experience.

It is preferred that observations be completed through Ascension St. Vincent. However, this is not a requirement. If you are wanting to observe at a different location that is not within Ascension St. Vincent, please have the supervisor at the desired observation location contact Ashlie Munchel at ashlie.munchel@ascension.org prior to you observing.

The program recommends that you complete around three (3) hours of observation within cardiac sonography. **Please read all of these instructions thoroughly if you would like to schedule observations. Observations are scheduled on a first come, first serve basis.** On page two you will find the available days and times for each observation requirement. Additionally, please read the HIPAA documents on pages 5-9 that further go over the guidelines to follow while observing. *****You must fill out and scan in the Observation Date and Time Request Form (page 2) and HIPAA forms (pages 5-9) and return it via email to Ashlie Munchel, Sonography Program Director, at ashlie.munchel@ascension.org to get your observations scheduled.**

Please read the instructions on page three to see where to report to for each observation. These instructions will let you know where to park, how to navigate through the hospital to find the correct area and who to ask for once you arrive. Please arrive at each location promptly wearing business casual attire. Please note that if you arrive for your observation and are not wearing business casual, you will be asked to leave. Additionally, you need to follow the rules of each department when it comes to being allowed to have your cell phone out. Please reserve cell phone use for emergencies only. You may take notes during your observation, if you desire. Additionally, on page three you find an **optional** observation log that you can fill out and turn in with our application.

Thank you,

Ashlie Munchel

Observation Dates and Times Request Form

Please read the following guidelines prior to filling in the table below. Cardiac observations may be completed Monday through Friday and can be 8a-11a or 1p-4p. Certain accommodations may be made at the director's discretion if the above dates and times do not work with your schedule.

Please list at least three dates below that you are available to complete the observations. Return this form (page 3) and the HIPAA forms (pages 5-8) to ashlie.munchel@ascension.org. I will then look at the availability and let you know what dates are confirmed. Observations are scheduled on a first come, first serve basis. Please give dates that are at least two weeks out from the date you are submitting the request. Please note that cancelling observation requests multiple times could result in the program director not rescheduling your observation request.

Cardiac **3 hours**
Day: Monday Tuesday Wednesday Thursday Friday Date: _____ Time (circle): 8a-11a 1p-4p
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Ascension St. Vincent College of Health Professions

Cardiac Sonography Program

Observation Locations

Cardiac Observation
Ascension St. Vincent Indianapolis Outpatient
Team Leader: Cheryl Hedges
8333 Naab Road Suite 400
Indianapolis, IN 46260

Phone: 317-338-6693

Please valet park at entrance 6 that is off of Naab Road. Walk into entrance 6 and walk straight back to the elevators. Take the elevators up to the fourth floor. Follow the yellow footprints down the hall. Pass the check in area and take a left. The echo department hallway should be on the right.

Cardiac Observation
Ascension St. Vincent Indianapolis Inpatient
Team Leader: Kaitlyn Kuebler
2001 West 86th Street
Indianapolis, Indiana 46260

Please park in the main associate parking lot. These spaces are in the back of the lot and are designated associate parking by white lines. Enter the main entrance of the hospital (entrance 1). Proceed past the volunteer desk on your right and follow the hallway as it jogs slightly to the left. Continue past outpatient lab and follow the hallway as it turns right. Take the elevators that are across from outpatient registration down to the basement. Turn left when exiting elevators and then take an immediate right. Just past the hallway on your right that leads to the professional office building will be a blue framed door on your left, which is the ultrasound waiting room. Please inform the front desk that you are observing in the **cardiac ultrasound department** for the day. They will get you in touch with a technologist.

Cardiac Sonography Program
Observation Log

Applicant Name: _____

Facility	Date	Hours	Concentration C: Cardiac	Supervisor's Signature

You may choose to turn this observation log in with your application packet.

Application for Shadowing/Job Observation Experience at Ascension St. Vincent Indianapolis Hospital

Important: *This form is to be completed in its entirety and submitted to the unit/department director for review and approval in advance of the requested date of observation.*

Shadower Information:

Name: _____
Last *First* *MI*
Address: _____

City: _____ **State:** _____ **Zip:** _____

E-Mail_____

Home Phone Number: _____ **Cell Number:** _____

Are you over the age of 16? YES / NO…….Date of Birth (MMDD): _____/_____

Last 4 digits of SSN: ____ ____ ____ ____

Proposed Date(s) of Shadowing Experience: _____

Proposed Times of Shadowing Experience: _____

In case of an emergency, who should be contacted?
Name: _____ **Relationship:** _____
Phone: _____

Please indicate the following: (You do not need to bring immunization records with you)

I will be able to show evidence of proof of immunization(signed by licensed nurse or health care provider immunity by laboratory result (positive titre), or natural disease history (diagnosed, documented, and signed by healthcare provider) of rubella (German measles), rubeola (measles), and varicella (chicken pox) and negative TB screening in the past year within 24 hours of request by hospital personnel…..YES / NO

Do you require any special accommodations due to medical limitations, disability or other restrictions? YES / NO……If yes, please explain below:
_____

Are your shadowing hours required for (check one):

School classes ____ Job investigation_____

If yes to any of the above, please explain the requirements for your shadower/observer experience:
_____

If observer is <u>under</u> the age of 18, parental guardian consent is required.

My son/daughter, _____, has my permission to participate in a St. Vincent Hospital and Health Services Job Shadow experience. As the parent/guardian of the above-named student, I will read the literature that is provided to my child so that I know what will be expected of him/her.

I attest that my child is at least 16 years of age and is free from communicable diseases and will be able to provide evidence of negative TB screening and **proof of immunization, immunity by laboratory results (positive titre), or natural disease history (diagnosed, documented, and signed by licensed healthcare provider), of rubella (German measles), rubeola (measles), and varicella (chicken pox) within 24 hours of request by hospital personnel.**

Participation in a job shadowing experience will include observing patients in a healthcare setting and observing medical, laboratory, and/or business procedures. I do hereby release Ascension St. Vincent Hospital, their staff and sponsors from any responsibilities of injury or accident as a result of the shadowing/observation experience. Any medical expenses incurred as a result of injury or accident will be my responsibility.

I understand that in case of a medical emergency, every attempt will be made to contact me before medical action is taken.

However, this document is my consent as parent or guardian for emergency treatment and/or procedures necessary for my son/daughter by the professional staff at Ascension St. Vincent Hospital.

Parent/Legal Guardian's Name (Printed)_____

Signature _____**Date**_____

****

FOR OFFICE USE ONLY:

Associate to be assigned supervision responsibility & escort for shadower/observer:

Name _____Associate ID_____

Photo ID Checked_____Date_____By _____

COMMENTS:

_____

_____

_____

Ascension St. Vincent Hospital
Consent and Release of Liability for Shadowers/Observers

My shadowing experience is to be performed on: Date/Time _____

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 St. Vincent 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.

Confidentiality:

I will hold all patient information in strict confidence. I understand no patient information is to leave Ascension St.Vincent premises, and I am not to discuss patient information with anyone other than the person I am shadowing. I understand that patient information includes not only patient names and other identifying information, but also any information related to a patient's condition, treatment, presence at the hospital, or any other information I heard, observed, or learned about any patient or patient's family members during my shadowing experience.

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 *St. Vincent Hospital Guidelines for Shadowing Experiences,* and have been given the opportunity to ask questions relating to my shadowing/observation experience.

Name of Shadower (Printed) _____

Signature of Shadower _____ Date:_____

□ If not 18 yrs. of age must ALSO be signed by Parent/Guardian □

Name of Parent/Guardian (Printed)

_____

Signature of Parent/Guardian

_____

Date:_____

Name of Witness (Printed) and Date - Signature of Witness

_____

This document is to be maintained by unit management in department files for at least two years past the shadower/observer experience.

Guidelines for Your Shadowing Experience

Welcome to Ascension St. Vincent Hospital. We are pleased that you have selected Ascension St. Vincent for your Shadowing Experience. To ensure your safety, as well as that of our patients, visitors, and associates, we have several guidelines which we ask that you follow during your time with us. If you have any questions about these guidelines, do not hesitate to ask your preceptor, or the manager of the area in which you are shadowing, at any time!!!!

1. Once you have submitted your Application and Consent for your shadowing experience, the manager of the area will confirm that date and time of your experience. The manager may also provide you with specific instructions regarding the experience which you must follow closely.

2. As a "shadower/observer", you must be supervised at **all times** by an Ascension St. Vincent associate. This associate will be your preceptor. They will make sure you stay safe, answer any questions you have, and familiarize you with the hospital. There may be some situations in which you cannot participate, in order to maintain a safe, private environment for the patient. Your preceptor will make you aware of those situations and ensure that either they or another assigned associate stays with you.

3. In no circumstance should you provide any care directly to the patient. You are to be observing only.

4. Please do not discuss any patient information with anyone other than your assigned preceptor. Although you may be eager to share your experiences with family and friends, all patient information must be kept confidential. Remember the old saying: "*What you see, what you hear, when you leave, leave it here!"*

5. Hospitals are full of germs!!!!! Remember to wash your hands with soap and water, or an alcohol-based disinfectant. Please wash your hands before entering a patient's room, upon leaving a patient's room, after you use the restroom, and prior to eating anything.

6. Do not come for your shadowing experience, if you are ill that day. Shadowers who display signs of illness, such as fever, cough, runny nose, chills, vomiting, etc. will be asked to leave immediately. If, at any point in your experience, you start to feel sick, faint, nauseated, or weak, please alert your preceptor. They will assist you.

   Dress Code: Please follow any specific instructions provided by your manager regarding dress code. Minimally, we ask that you comply with the following:

   1. Business casual dress: This would include trousers and polo or oxford-type shirts for men and slacks/skirts and blouses or dresses for women. Please no blue jeans, capris, or shorts. Dress comfortably, yet professionally. You will, more than likely be on your feet a lot and moving frequently. Shoes should be comfortable with enclosed toes. Hosiery must be worn. No sandals, flip-flops, peep toes, or Crocs with holes are permitted.

   2. All tattoos must be covered.

   3. Refrain from wearing excessive jewelry. Small post-earrings in the ear are permitted. Body piercings in areas other than the ear must be covered or removed.

   4. Please bring a photo I.D. with you for identification purposes.