EISENHOWER MEDICAL CENTER
Shadow Request / Consent Form

I, ______________________________ (print name) wish to observe patient care in a health care setting at Eisenhower Medical Center ("EMC") in the ______________________________ Department.

List two objectives you hope to accomplish with this job shadow experience:

1. ______________________________ 2. ______________________________

I, the undersigned, hereby certify that my participation as a non-paid observer ("Activity") at EMC and its wholly owned clinics is entirely voluntary. This Activity is for my personal enrichment and learning. I understand and recognize that I am responsible for my own well-being during my participation in the Activity. To the best of my knowledge, I am not aware of any physical disability or health related reasons which would preclude or restrict my participation in the Activity.

NOW, THEREFORE, in consideration of being allowed to participate in the Activity, I agree to hold EMC and its Trustees, employees, agents and/or representatives harmless from any and all direct, indirect, special or consequential damages, costs, legal or otherwise, which I may incur as a result of my participation in this Activity. This Release/Agreement shall be binding upon my heirs, administrators, executors, and assigns. In signing this release, I acknowledge and represent that I have read the foregoing Release/Agreement, understand it and sign it voluntarily; no oral representations, statements or inducements, apart from the foregoing written agreement, have been made; I am fully competent and I execute the Release/Agreement for full, adequate and complete consideration fully intending to be bound by the same.

MOREOVER, I have received a copy of EMC's Code of Conduct, Confidentiality Agreement, Elder & Child Abuse Reporting Requirement and promise to abide by all rules contained therein.

X______________________________

Full Name (Please Print) ______________________________

Date______________________________

____
Signed Parent/Guardian Permission if participant is under 18 years of age

____
Parent Name

____
Date

____
Telephone Contact

Contact Information:

Address: ______________________________

____

Phone: ______________________________

Emergency Contact Information:

Name: ______________________________

Relationship: ______________________________

Phone: ______________________________

Address: ______________________________

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Assigned "Shadow" Department: ______________________________

Assigned "Shadow" Staff: ______________________________

Date(s) of Experience: ______________________________

Department Director Arranging the Experience: ______________________________

Form Distribution: Original – Director Copy – "Shadow" Staff Copy – Human Resources