Dear Job Shadow Applicant,

Thank you for your interest in job shadowing with Mason Health. Please fill out the packet then return the completed packet via email to volunteer@masongeneral.com. Please note that your paperwork must be submitted as one complete packet. If any pieces of the packet are missing, we will be unable to process your application.

The packet includes the following documents:

- The Application
- Public Venue Release Form
- Vaccination Forms – *Please note that for a Job Shadow, you are not eligible to receive a vaccination from Mason Health through the job shadow program*

If you are unable to email your completed packet, you may mail it to:

Volunteer Office
Mason Health
901 Mountain View Drive
P.O. Box 1668
Shelton, WA 98584-8614

After your paperwork is received, we will advise you of the next steps in the onboarding process via email within 2 weeks. If you have further questions or concerns, the Volunteer Office can be reached at (360) 427-3621, or volunteer@masongeneral.com.

We value our job shadow applicants. Thank you for your interest!

Sincerely,

Kim Lutey | Volunteer Program Specialist

Mason Health
Mason General Hospital • Mason Clinic

901 Mountain View Drive POB 1668
Shelton, WA 98584
Phone: (360) 427-3621 | Ext. 28899
Cell: (360) 968-0001 | Fax: (360) 432-3267
Email: klutey@masongeneral.com

Mason Health
Mason General Hospital • Mason Clinic

Community Job Shadow Application

Community Job Shadow Application

901 Mountain View Dr • PO Box 1668 • Shelton, WA 98584 • (360) 427-3621 • volunteer@masongeneral.com

Contact Information

First Name _____ Last Name _____

Date of Birth _____ Home Address _____

City _____ State _____ Zip _____ Preferred Pronouns (She/Her, They/Them, etc. _____

Cell Phone _____ Email _____

How do you prefer to be contacted? ☐Email ☐Phone Call ☐Text

Area of Interest (choose all areas you want to shadow)

☐ Nursing ☐ Pharmacy Tech ☐ PT/Rehab ☐ MD/DO/ARNP/PA ☐ Phlebotomy

☐ Pediatrics ☐ Culinary Services ☐ Clinic Specialty Care ☐ Diagnostic Imaging

☐OB/GYN ☐ Anesthesia ☐ Hospital Tech ☐ Other: _____

What job position would you like to shadow (i.e. Doctor, Nurse, etc.) _____

Emergency Contact & Age of Applicant Verification

Mason Health requires Parent/Guardian approval if the applicant is younger than 18 years old.

☐ I certify that I am 18+ years of age at the signing of this application.

☐ I am younger than 18 and will have a parent/guardian sign the approval form (attached).

In case of emergency please notify:

Name _____ Relationship_____ Phone _____

Questions

What is your interest in this field?

_____

_____

How did you learn about this opportunity? _____

What day(s) and time(s) are you available to shadow? _____

Is this job shadow a requirement for your school? If so, list the degree(s) you are pursuing, how many hours are required, and the name of the school:

_____

Do you need the job shadow to be completed by a certain date? If so, please list the date: _____

How many job shadow opportunities are you hoping for? (i.e. one day, four days, etc.)

_____

Mason Health
Mason General Hospital • Mason Clinic

Community Job Shadow Application

Certification, Authorization & Release

I have read and understand the information provided to me on Job Shadowing at Mason Health. It is understood Job Shadowing at Mason Health can lead to exposure to infectious diseases. Should I need medical attention during or as a result of this job shadowing experience, I assume full responsibility for any treatments deemed necessary. I assume responsibility of all medical costs which result and release Mason Health and its members of all liability. By signing this consent form, you acknowledge that you should not job shadow on a day you are experiencing any illness.

Patient must give written permission for any job shadow interactions. I understand that this permission may be withdrawn by the patient at any time. I give Mason Health permission to release my telephone number or email to the requested host department(s) for scheduling and communication purposes. While I am job shadowing at any site under Mason Health, I realize that all healthcare information, patient care, and records are a confidential matter. All information exchanged while I am observing must be held in strictest confidence.

Printed Applicant Name: _____ Date/Time: _____

Signature: _____

Parent/Guardian Certification, Authorization & Release

I have read and understand the information above and authorize my child/ward to participate in this job shadowing experience. Mason Health nor its members shall be held responsible for adverse occurrences and/or outcomes from participating in the job shadow experience. By signing this consent form, you knowledge that your child/ward should not job shadow on a day they are experiencing any illness.

Should my child/ward need medical attention during or as a result of this job shadowing experience, I authorize such medical care and assume full responsibility for any treatments deemed necessary. I assume responsibility for all medical costs which result and release Mason Health and its members of all liability. I give Mason Health and its members permission to release my child/ward's telephone number or email to the requested host department(s) for scheduling and communication purposes.

Printed Parent/Guardian Name: _____ Date/Time: _____

Signature: _____

Mason Health
Mason General Hospital • Mason Clinic

Employee Health
Tel: 360-432-7704
Fax: 360-432-7751

COVID-19 VACCINE CONSENT/DECLINATION

PLEASE PRINT			
Last Name:		First Name:	Employee ID #:
Date of Birth:	Department:	(Circle One): Contracted Provider Volunteer	

	YES	NO
1. Have you ever had a covid-19 shot before?		
2. Ever had any problems or allergic reaction to the covid-19 shot?		
3. Are you sick today or do have a fever?		
4. Are you allergic to eggs or latex?		
5. Do you have a history of Guillain Barre Syndrome?		

☐ **I choose to receive the 2024-2025 Covid-19 vaccine.** In signing below, I release Mason General Hospital and Family of Clinics or any of its employees responsible for any possible untoward effects related to this vaccine administration. I further assume all responsibility for obtaining medical or other professional help for any health problems that may occur as a result of this immunization. I understand side effects may occur. I have had the opportunity to ask questions. I also approve to have this healthcare information faxed to the Employee Health Department of the facilities I have indicated on this form.

I have been provided with the Emergency Use Authorization sheet corresponding to the COVID-19 vaccine that I am receiving. I have read or had read to me the information provided about the COVID-19 vaccine and this Consent Form. I have had the chance to ask questions that were answered to my satisfaction. I understand the nature, alternatives, benefits and risks of vaccination. I understand the COVID-19 vaccine requires two doses and that as with all vaccines there is no guarantee that I will become immune or that I will not experience side effects. I have made the decision to receive the COVID-19 vaccine voluntarily and freely and I assume full responsibility for any reactions that may result. I understand that I should remain in the vaccine administration area or an area identified by my health care provider for 15 minutes after the vaccination to be monitored for any potential adverse reactions. I understand if I experience side effects that I should do the following: call Mason Health, my doctor, or call 911. I request that the vaccine be given to me or the stated person named above for whom I am authorized to make this request.

☐ I **do not** wish to receive the Covid-19 2024-2025 vaccine.

☐ **I have already received the 2024-2025 Covid-19 vaccine**. *Copy attached*.

Signature:	Date:

For Office Use Only			
Vaccine:		**Date on EUA fact sheet:**	
Date Given:		**Injection Site**	Left Right
Manufacturer, Lot #, Exp. Date		**Nurse Signature:**	

Mason Health
Mason General Hospital • Mason Clinic

Employee Health
Tel: 360-432-7704
Fax: 360-432-7751

INFLUENZA VACCINE CONSENT 2024-2025

PLEASE PRINT			
Last Name:		First Name:	Employee ID #:
Date of Birth:	Department:	(Circle One): Contracted Provider Volunteer	

	YES	NO
1. Have you ever had a flu shot before?		
2. Ever had any problems or allergic reaction to the flu shot?		
3. Are you sick today or do have a fever?		
4. Are you allergic to eggs or latex?		
5. Do you have a history of Guillian Barre Syndrome?		

☐ **I choose to receive the flu vaccine.** In signing below, I release Mason General Hospital and Family of Clinics or any of its employees responsible for any possible untoward effects related to this vaccine administration. I further assume all responsibility for obtaining medical or other professional help for any health problems that may occur as a result of this immunization. I understand side effects may occur. A Vaccine Information Statement was available for me and I have had the opportunity to ask questions. I also approve to have this healthcare information faxed to the Employee Health Department of the facilities I have indicated on this form.

There are many different flu viruses and they are constantly changing. The composition of U.S. flu vaccines is reviewed annually and updated as needed to match circulating flu viruses. Flu vaccines protect against the three or four viruses (depending on vaccine) that research suggests will be most common.

☐ I **do not** wish to receive the flu vaccine.

☐ **I have already received the 2024-2025** flu vaccine. *Copy attached*.

Signature:	Date:

For Office Use Only			
Vaccine:	Inactivated Influenza Vaccine	**Date on VIS:**	**08/6/2021**
Date Given:		**Injection Site**	Left Right
Manufacturer, Lot #, Exp. Date		**Nurse Signature:**	

Mason Health
Mason General Hospital • Mason Clinic

2024 ANNUAL TB SYMPTOM EVALUATION FORM:

MGH & FC has completed an annual assessment for Tuberculosis risk and this year we have been classed as "**LOW RISK**". As such, we are not required to do annual skin testing. However, every employee must complete and return to Employee Health a "**TB Symptoms Evaluation**" form.

Print Name: _____ **Date of Birth** ____/____/_____

Department: _____

Signature: _____ **Date:** __/__/_____

Please check any of the following signs and symptoms of tuberculosis that you may be experiencing at this time:

I currently have the following signs and symptoms:

☐ Coughing (>3 weeks)	☐ Chest pain	☐ Fatigue
☐ Night sweats (not hormone related)	☐ Coughing up blood	☐ I have been exposed to someone with active TB in the past year
☐ Unintentional weight loss	☐ Loss of appetite	☐ Fever/chills

☐ I am **NOT** experiencing **ANY** of the above signs and symptoms

If you are concerned at any time that you may have TB symptoms, or been exposed to TB contact Employee Health at ext. 28851 M-F 7am-3:30pm or the House Supervisor ext. 27000

Mason Health
Mason General Hospital • Mason Clinic

PUBLIC VENUE RELEASE FORM

The undersigned hereby consents to the use of their personal information as identified below, by Public Hospital District No. 1 of Mason County, WA (doing business as Mason Health) and waived the right to inspect or approve such photos, stories, etc. or to receive any monetary compensation for this photo, story, etc. **A copy of this release form may be provided upon request.**

This information will be used for the following marketing campaign/purpose _____

The following Personal Information about myself or child may be used:

- ☐ Name (Please print) _____
- ☐ Name of Baby/Child (Please print) _____
- ☐ A photograph (picture) of myself
- ☐ A photograph (picture) of child
- ☐ Company Name _____
- ☐ The following information (attach a separate sheet if needed) _____
- ☐ Date of Birth _____

Please provide your contact information so we may contact you if necessary. This information will not be shared.

_____ Home Address

_____ Email

_____ City, State, Zip

_____ Phone Number

I agree that my information may be used in all of the following publications, except _____

- Mason Health Web Page
- Internet and Telephone Directories
- Newspapers and Happenings Newsletters
- Radio and Television
- Scope, Making the Rounds or other District Publications
- Reader Board
- Digital Stories, DVD's, as well as any and all social media and web based (and other) media outlets
- Any Years of Service recognition for duration of employment
- Individual Physician or Allied Health Profiles
- Educational material, i.e. flyers, banners, pamphlets
- Donor or Volunteer Recognition
- MGH Foundation Publications
- In the case of digital stories, videos, etc. I have reviewed the materials produced and I approve the final digital story/DVD that has been produced

_____ Signature of Client or Legal Guardian

_____ Date

Revocation of Public Venue Release

If, in the future, you no longer want Public Hospital District No. 1 of Mason County, WA, to use your information in a public venue, you need to contact Mason Health and sign a revocation statement. This can be done in person or via a fax notice to 360-427-1921.

I no longer want my personal information used in a public venue. I understand that it may take up to 60 days for this revocation to be put into effect.

_____ Signature

_____ Date

Return this form to the

Mason Health Development Office
PO Box 1668
Shelton, WA 98584
Call 360-427-3623 or email
foundation@masongeneral.com
if you have questions.

PUBLIC VENUE RELEASE FORM
Mason Health
PO Box 1668, 901 Mountain View Drive
Shelton, WA 98584