MAURY REGIONAL HEALTH

2023-2024 Work-Based Learning (WBL) PROGRAM

Coordinated through Volunteer Services & Maury County Board of Education

<u>WBL Program Details and Requirements:</u>

- WBL participants ***MUST BE FULLY VACCINATED*** (either two doses of Pfizer/Moderna or one dose of Johnson & Johnson) to be eligible to participate in the program. Documentation of vaccination will be required as part of their packet. Those that do not submit proof of vaccine with their packet at Orientation will not be accepted into the program.
- WBL Orientation will be held on ***<u>Thursday, September 7, 11am-1:30pm</u>*** in the Auxiliary Conference Room, located in the main hospital on the first floor. Students will need to provide their own lunch, beverages will be provided. ***<u>Orientation is Mandatory – NO Exceptions!</u>***
- Program will begin Tuesday, September 12. Student/Department rotations will take place when the program convenes on January 9, 2024. Participants will receive their new assignment prior to Christmas dismissal.
- WBL participants will have the opportunity to attend the following special educational sessions. ***<u>Students are required to attend all sessions. More Information to come.</u>***
  - Financial Literacy Program (with First Farmers Bank)
  - Professional Dress and Interview for Success
  - Building Your Resume and College Prep
  - Maury Regional Medical Center Human Resources Dept.
- Students will be required to complete the enclosed survey that will be ***emailed at completion of the program***. Enclosed survey requires parental consent only.
- All participants will complete a Capstone project at completion of the program. If photos will be utilized as part of final project, please follow (HIPAA) Health Insurance Portability & Accountability Act (*Patient Privacy and Security*) guidelines in regard to photos.

PERSONAL INFORMATION:

Last Name: ______________________ First Name: __________________ MI: _________

Date of Birth (MM/DD/YY): ___________________

Home Address: ____

City/State: ___________________________ Zip Code: _____________

Student Cell Number: ___________________________

Personal Email **(please do not use your school email)** for Communication: ____________________

Name of High School: _______________________________

In Case of Emergency, Please Notify (Parent/Guardian – Local Person Only):

Name: _____________________________ Relationship: ____________________

Contact Number(s): ____

Please provide one additional emergency contact:

Name: ______________________________ Relationship: ___________________

Contact Number(s): ____

Do you have any physical conditions which may limit your activities or abilities?

YES __________ NO ____________

If yes, please explain:

Have you been *_fully vaccinated_ against COVID -19? Yes ☐ No ☐

*To be fully vaccinated one must receive either two doses of Pfizer/Moderna or one dose of Johnson & Johnson. Documentation of vaccination MUST BE SUBMITTED WITH APPLICATION at Orientation.

Please check from the list any medical field you might be interested in pursuing:

- ☐ Audiology
- ☐ Bio-Med
- ☐ Cardiology
- ☐ Dietary/Food & Nutrition
- ☐ Home Health
- ☐ Nursing
  - ☐ RN
  - ☐ Advanced Practice
  - ☐ CRNA
- ☐ Medical Technologist
- ☐ Occupational Therapy
- ☐ Pathology
- ☐ Pharmacy
- ☐ Physical Therapy
- ☐ Physician
- ☐ Radiology
- ☐ Respiratory Therapy
- ☐ Social Work/Case Management
- ☐ Speech Therapy
- ☐ Other _______________

Do you have any friends, relatives, or acquaintances employed by or volunteering at Maury Regional Medical Center? ☐ YES ☐ NO If yes, please list below:

Name Position Relationship

1. ____
2. ____
3. ____

MRMC PROCESS/REQUIREMENTS FOR WORK-BASED LEARNING (WBL)

- All WBL Student will report to Volunteer Services EVERY DAY they are scheduled. Volunteer Services is located in Medical Office Building A, Suite 112 (just inside the door on the left)
- Upon arrival, sign in and pick up your WBL ID badge. A volunteer will be available to assist you. If you are shadowing 'off-campus' you will still need to stop by to sign in/out and pick up/drop off your WBL ID badge.
- WBL badges have **NO ACCESS**, so student will NOT have access within the hospital without supervision of a MRMC employee (nurse/nurse tech).
    - Students currently employed at MRMC are **NOT PERMITTED** to use their employee ID badge for access throughout the hospital when here as a WBL participant.
    - As a WBL participant, students are **NOT PERMITTED** to participate in patient care. **STUDENTS ARE HERE TO OBSERVE ONLY**! ***Students are NOT covered by employee status!***
- Once your shift has ended, return to Volunteer Services to sign out and return your ID badge.
- The WBL program follows the school schedule. When schools are closed due to weather, testing, holiday, etc., student will NOT report to MRMC.
- ALL WBL participants are required to wear their MRMC WBL/MASH polo shirt with khaki, navy, black, white pants or black scrubs and close-toed shoes **(no crocs).**
    - ***No jeans, ripped or torn clothing is permitted.***
- If WBL participant is sick and will not be able to present for his/her scheduled assignment, ***STUDENT IS REQUIRED TO CONTACT VOLUNTEER SERVICES AT 931.380.4047 IMMEDIATELY*** or it will be counted as an absence.
- *Communication between the WBL participant and Volunteer Service is critical! Please respond to all emails, texts, etc. in a timely manner. In addition, it is YOUR RESPONSIBILITY to notify your department and Volunteer Services when you will be absent from your scheduled shift due to illness, vacation, testing, etc. Failure to do so could result in dismissal from the program.* ***Each time you do not respond to an email and/or text or fail to notify us that you will be absent from your scheduled shift will result in a mark against you. If you receive three (3) marks, you will be dismissed from the program – no exceptions.***

As a participant in the Work- Based Learning program at Maury Regional Medical Center, I agree to the requirements listed above and understand if I do not abide by these guidelines I could be dismissed from the program.

Participant Name (Print): ______________________________ Date: __________________

Signature: ____

Parent Name (Print): _________________________________ Date: __________________

Signature: ____

MRMC Representative: ________________________________ Date: __________________

Signature: ____

Work-Based Learning
Personalized Learning Plan

Student Name:

Placement Date:

Placement Site:

WBL Coordinator:

Up-to-date copies of the Safety Training Log and the Work-Based Learning Agreement must be kept on file both at the work site and at the school for all WBL placements as required by Tennessee Child Labor Law and consistent with the Department of Education's WBL Policy Guide.

This packet is required for students earning credit through *Clinical Internship (5993), Nursing Education (6000), Work-Based Learning: Career Practicum (6105),* or *Work-Based Learning: Special Education Transition (6107)*. Complete this packet for all credit-bearing experiences to ensure compliance with the State Board of Education's WBL Framework, with federal and state child labor laws, and with the Department of Education's WBL Policy Guide.

TN Department of Education

WBL Safety Training Log

The following safety training log should reflect the training requirements appropriate for the student's job description and align with the required trainings of the business. According to Tennessee Child Labor Law and WBL Policies, this form must be kept up-to-date in the personnel file at the workplace and at the school. Copies of the Safety Training Log and the WBL Agreement must be kept on file at the school for five years after placement.

Student Name:	**Work Site:**
Address:	**Address:**
City/Zip:	**City/Zip:**
Phone:	**Phone:**
DOB:	**Supervisor:**

Student's Responsibilities/Job Description:____

____

Safety Training Topics*	Trainer's Name	Location	Date Provided
1.			
2.			
3.			
4.			
5.			
6.			
7.			

**If additional space is needed, attach an extra sheet of paper.*

SIGNATURES *(all identified individuals must sign below prior to the start of the student placement)*

Student:		**Date:**
Parent or Guardian:		**Date:**
Endorsed Teacher: *(When not the WBL Coordinator)*		**Date:**
WBL Coordinator:		**Date:**
Principal:	**School:**	**Date:**
CTE Director: *(or designated WBL Coordinator)*		**Date:**
Work Site Supervisor:		**Date:**

Note: It is the policy of the school district that no person on the basis of race, color, religion, national origin or ancestry, age, sex, marital status, disability, or disadvantage should be discriminated against, excluded from participation in, denied the benefits of, or otherwise be subjected to discrimination in any program or activity. This form is subject to monitoring by TDOE and/or TDOL&W

TN Department of Education

WBL Agreement

According to Tennessee Child Labor Law and WBL Policies, this form must be kept up-to-date in the personnel file at the workplace and at the school. Copies of the Safety Training Log and the WBL Agreement must be kept on file at the school for five years after placement.

Student Name:		**Work Site:**
Address:		**Supervisor:**
City/Zip:		**Address:**
Phone:	**DOB:**	**City/Zip:**
Area of Elective Focus:		**Phone:**
High School:		**Start Date:**

Typical Weekly Work Schedule: *Hours for credit-bearing experiences must equate to a full-time equivalent course.*

Day	Time of Work		Total Work
	From	To	
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			
		Total	

Type of WBL experience

- ☐ Apprenticeship (Registered)
- ☐ Clinical
- ☐ Cooperative Education
- ☐ Internship
- ☐ Transition (paid or unpaid)
- ☐ School-Based Enterprise
- ☐ Service Learning

Employability Skills: *This student is participating in work-based learning for credit and will have the opportunity to practice employability skills appropriate to the placement to prepare them for postsecondary education, future careers, and life:*

- **Application of academic and technical knowledge and skills**
- **Career knowledge and navigation skills**
- **21st Century learning and innovation skills**
- **Personal and social skills**

Verification: We, the undersigned, give permission for the above-named student to participate in the WBL program, and we understand and agree to meet the requirements of the WBL Framework as provided in State Board of Education policy and in the WBL Policy Guide provided by the Tennessee Department of Education. We verify the above information is correct and is consistent with federal and state guidelines for work-based learning experiences.

Student:		**Date:**
Parent or Guardian:		**Date:**
Endorsed Teacher: *(When not the WBL Coordinator)*		**Date:**
WBL Coordinator:		**Date:**
Principal:	**School:**	**Date:**
CTE Director: *(or designated WBL Coordinator)*		**Date:**
Work Site Supervisor:		**Date:**

Note: It is the policy of the school district that no person on the basis of race, color, religion, national origin or ancestry, age, sex, marital status, disability, or disadvantage be discriminated against, excluded from participation in, denied the benefits of, or otherwise be subjected to discrimination in any program or activity. This form is subject to monitoring by TDOE and/or TDOL&WD.

VERIFY WORKERS' COMPENSATION COVERAGE: ________**YES** __________**NO**

TN Department of Education

WBL Insurance and Emergency Information

Student Name:		**Work Site:**	
Address:		**Address:**	
City:	**Zip:**	**City:**	**Zip:**
Phone:		**Phone:**	
DOB:	**Grade:**	**WBL Coordinator:**	

Allergic to Medication? ☐ No ☐ Yes If yes: list medication(s):____________________________________

List any other allergies or medical problems:____

Medical Alert: ☐ No ☐ Yes, If yes: additional explanation:____________________________________

Insurance Company:_________________________Policy #:__________________________________

Parent/Guardian	**Home Phone:** **Work Phone:** **Cell Phone:**
Parent/Guardian	**Home Phone:** **Work Phone:** **Cell Phone:**
Additional Emergency Contact	**Home Phone:** **Work Phone:** **Cell Phone:**

I consent for my child to receive medical treatment in case of injury or illness. The information provided is accurate to the best of my knowledge.

Parent or Guardian	**Date**
Student	**Date**
WBL Coordinator	**Date**
Principal	**Date**
Supervisor	**Date**

Note: It is the policy of the school district that no person on the basis of race, color, religion, national origin or ancestry, age, sex, marital status, disability, or disadvantage should be discriminated again, excluded from participation in, denied the benefits of or otherwise be subjected to discrimination in nay program or activity. This form is subject to monitoring by TDOE and/or TDOL&WD.

PERMISSION TO PARTICIPATE (Parental Form)

I hereby permit my son/daughter ______________________________________ to participate in the Work Based Learning (WBL) Program at Maury Regional Medical Center**. I agree, on behalf of myself, my family, and my personal representatives, to release, indemnify, defend and hold Maury Regional Medical Center, its Board of Trustee members, officers, employees, agents, and any of its affiliates harmless from and against all claims, damages or losses of whatever nature, by me or any third party, that arise out of or in connection with my son's/daughter's participation in the WBL Program. I shall pay all costs, including attorneys' fees and court costs, as well as damages flowing from any such claims by third parties.

****

CONSENT TO PHOTOGRAPH/VIDEOTAPE

The undersigned hereby authorizes the taking of photographs, videotaping and/or audio taping of ________________________________, a Work Based Learning program participant at Maury Regional Medical Center**. I do hereby release Maury Regional Medical Center and its affiliates, their officers, Board of Trustee members, employees, agents and any other representatives, from any and all liability related to, or arising from, the use of such photograph/videotape/audiotape described above by Maury Regional Medical Center or its affiliates at any time. I understand and agree that I am not entitled to any compensation or other benefit, now or at any time in the future, for the use of such photograph/videotape/audiotape by Maury Regional Medical Center or its affiliates at any time.

____
Applicant Signature

____
Parent/Guardian Signature

____
Volunteer Services Representative

____
Date

**Maury Regional Hospital d/b/a Maury Regional Medical Center August 2022

VOLUNTEER ACKNOWLEDGEMENT AND RELEASE OF LIABILITY

I, the undersigned, am willing to volunteer my personal services to Maury Regional Hospital d/b/a Maury Regional Medical Center ("MRMC"), Maury Regional Hospital d/b/a Marshall Medical Center ("MMC") or Maury Regional Hospital d/b/a Wayne Medical Center ("WMC") (collectively, "MRH") on an as-needed basis in my sole discretion. While in no way limiting the foregoing, I specifically acknowledge and agree as follows:

1. My services as a volunteer may result in my exposure to and/or contraction of infectious diseases (including but not limited to COVID-19). I acknowledge that my willingness to volunteer at MRH is a completely voluntary action in all respects and I assume, on behalf of myself, my family and all third parties, any and all risks (including but not limited to serious illness, death, monetary damages, and any other loss) associated with my exposure to and/or contraction of any and all infectious diseases while providing volunteer activities at or on behalf of MRH.
2. The Centers for Disease Control has recognized that certain individuals are at significantly greater risk for a poor outcome if they contract COVID-19, as well as other infectious diseases, and specifically individuals who are (i) over the age of 65, (ii) immunocompromised, (iii) have COPD, (iv) have congestive heart failure, (v) have diabetes or (v) are pregnant. I acknowledge that I have been advised of these elevated risk categories and I assume all consequences which may result if I am a member of an elevated risk category and choose to participate as a volunteer at or on behalf of MRH.
3. I acknowledge on behalf of myself, my family, and my personal representatives to release, indemnify, defend and hold Maury Regional Hospital and its affiliated entities (including but not limited to MRMC, MMC and WMC), their governing Board members, officers, employees, and agents harmless from and against all claims, damages or losses of whatever nature, that arise out of or in connection with my exposure to and/or contraction of an infectious disease, including but not limited to COVID-19, while providing volunteer activities at or on behalf of MRH.
4. In the event of an emergency, I authorize any physician and/or medical personnel to provide any treatment deemed necessary for my immediate care and agree that I will be responsible for the payment of any and all medical services so rendered to me or on my behalf.
5. This Acknowledgement and Release of Liability shall be effective from the date indicated below and remain effective indefinitely or until such date that written revocation is provided by me. Upon my revocation of this Acknowledgement and Release of Liability, I shall no longer be permitted to provide volunteer services at or on behalf of MRH.

I have read and fully understand this Acknowledgement and Release of Liability as set forth above.

Signed: ________________________________ Printed Name: ________________________________

Date: __________________________________ Witness: ____________________________________

DO NOT COMPLETE SURVEY. The survey will be emailed at completion of the program. PARENTAL CONSENT SIGNATURE REQUIRED ONLY.

Work-Based Learning Program Survey

Thank you for participating in the Work Based Learning Program at Maury Regional Health. Your input will be invaluable as we continue to shape the WBL Program to one that is a truly meaningful experience.

* 1. **PARENTAL CONSENT**: *We, the undersigned, give permission for the below-named student to share their experience in the Work-Based Learning Program by completing this survey. We understand the results from the survey will be used to improve future programs.*

Student Name (Print)/Date: ____________

Parent or Guardian Signature/Date: ____________

WBL Coordinator/Date: ____________

* 2. Department Assigned:

Fall Semester: ____________

Spring Semester: ____________

* 3. What did you find most interesting about your Work Based Learning experience?

* 4. Describe the most valuable things you learned by participating in the program.

* 5. Would you recommend this program to an upcoming senior for next year? Why or why not?

* 6. What suggestions do you have on how we can improve the program?

* 7. What else would you like to share about the program? Was there anyone special that mentored you and you would like to recognize?

Thank you for completing this survey, for it will help us to improve the program for future participants.

JOB SHADOW PARTICIPATION ACKNOWLEDGEMENT & STATEMENTS OF AGREEMENT

JOB SHADOW PARTICIPANT: ______________________ (Phone #) ______________________ **IS A:**
Print Name

____Minor (14 to 17 years old) ***Requires signature of parent or legal guardian.***

____Adult (18 years old or greater)

ACKNOWLEDGEMENT:

The Job Shadow assignment will typically not exceed 40 hours or five (5) work days per nursing department. **THIS ASSIGNMENT WILL BE FOR OBSERVATION ONLY AND NOT FOR DIRECT PATIENT CARE.** The location and timing of the Job Shadow assignment is as follows:

Department: ______________________ Schedule / Dates: ______________________

STATEMENTS OF AGREEMENT:

Confidentiality

All patient medical and financial information, employee records, financial and operating data of Maury Regional Medical Center, and any other information of a private or sensitive nature are considered confidential.

I hereby certify that any such information of which I become aware in the course of my time with Maury Regional Medical Center is confidential, and that I **will not discuss** or in any way disclose any such information which can be associated with the identity of the hospital, its staff, its patients, and/or its patient records.

I understand that the disclosure of such information may give rise to irreparable injury to the patient, hospital or to the provider of such information; and that I, or my parents/guardians, will be held liable for any damages arising from any disclosure.

I agree to indemnify, defend and hold the Hospital harmless from and against any and all liability, losses, damages, claims, or causes of action, including any third party action, arising out of any breach of confidentiality by me.

I understand the inherent dangers in participating in a job shadow experience at a health care facility and accept the risks of being around sick and injured patients. These risks include, but are not limited to, being emotionally shocked by experiences that are new, unusual, or distressing; being adversely affected by the sight of blood or other bodily fluids, physical trauma, death, nudity, altered states of consciousness, and uncomfortable or painful medical procedures or tests; fainting; and being exposed to illness, infection or injury.

Personal Appearance

I agree to comply with the Hospital's Personal Appearance Policy. Attire cannot include: jeans, sweatpants, tank tops/bare midriffs, baggy clothes or clothes that drag the floor, exposed undergarments or sandals/flip flops. Three earrings may be worn in each ear, however, all other body piercing is not to be visible and tattoos must be covered. Shoes should be comfortable and closed toe.

Injury or Illness

Further, I agree that I will not hold Maury Regional Medical Center liable for any injury or illness that may occur to me as a result of my job shadowing participation. This release from liability includes, but is not limited to, any problem or injury to me that arises while en route to and/or home from the hospital, or that occurs while at the hospital or on hospital property.

Participant's Signature: ______________________ **Date:** ____________

IF PARTICIPANT IS A MINOR:

I, ______________________ am the parent / legal guardian of ______________________,
Print Name of Parent/Legal Guardian — Print Name of Minor Participant

have read this complete document and agree that my child will adhere to the statements made above. As the parent/legal guardian of the minor participant I also agree to the statements made in this document.

Parent's Signature: ______________________ Date: ____________

Human Resources: ______________________ Date: ____________

MAURY REGIONAL MEDICAL CENTER

Job Shadow Questions Worksheet

Department:

Position:

What are 2-3 personal goals for the day?

1. ______________________________
2. ______________________________
3. ______________________________

- How did you get started in this field?
- What was your education? Degree, certification, experience, etc.
- What other educational background would be helpful for this field?

- Describe a typical day for you.
- Describe your job duties.
- Describe the work conditions.

- What do you like most about your job?
- What do you find most rewarding about your work?

- What are your toughest challenges at work?
- Are there any industry-wide challenges?
- Is there any action being taken to solve these challenges?

- What obligation does your work put on you outside the work week?
- How much flexibility do you have in terms of work hours, vacations, etc?

- What types of employers hire people in this field?
- Are there any comparable jobs to this one?

- Are there any career advancement opportunities?
- Is turnover high in this field?

Advice:

Notes:

ACCEPTANCE STATEMENT

Please initial in the space below indicating your understanding of each statement*:*

____ I have completed the application in its' entirety.

____ I understand as a participant in the program I am required to attend Orientation on September 7, 11am-1:30pm, located in the Auxiliary Conference Room (1st floor, main hospital). Students will need to provide their own lunch. Beverages will be provided.

____ I understand that the current WBL schedule could change at any time due to the ever-changing COVID situation. Our priority is to keep everyone safe and unfortunately, this could involve eliminating some of the scheduled activities.

____ I understand I must be fully vaccinated (two doses of Pfizer/Moderna or one dose of Johnson & Johnson) against COVID-19 to participate in the program. Proof of vaccine must be submitted with my packet at Orientation on September 7. If I have not submitted proof of vaccine at Orientation, I will forfeit my spot in the program.

____ I will abide by the guidelines set forth by the Program Coordinator. I understand the importance of communicating and responding to email/text messages sent in regard to the WBL Program. I also understand I can be dismissed from the program if I fail to do so.

____ I understand this application and all additional documents must be submitted in full at WBL Orientation on September 7 to secure my position in the program.

The following items are to be submitted at Orientation on September 7.

- ☐ Completed Application (Personal Information/Field of Interest)
- ☐ Parent/Student/Teacher signatures on the following forms:
  - Process/Requirements for WBL Program
  - WBL Personalized Learning Plan
  - WBL Safety Training Log
  - WBL Agreement
  - WBL Insurance & Emergency Information
  - Permission to Participate
  - Consent to Photograph/Videotape
  - Volunteer Acknowledgement and Release of Liability Form
  - Work Based Learning Program Survey (to be completed at end of program)
  - Job Shadowing Participation Acknowledgement & Statements of Agreement
  - Copy of COVID-19 Vaccination Record - ATTACHED
  - Acceptance Statement

My packet is complete with the above signed forms as requested, along with a copy of my COVID -19 Vaccination card.

For any questions, please contact Cindy Short at 931.380.4047 or cshort@mauryregional.com