



# STEELE MEMORIAL MEDICAL CENTER

203 S. DAISY ST. ~ SALMON, IDAHO 83467 ~ (208)756-5600 ~ FAX (208) 756-4169

HUMAN RESOURCES ~ (208) 756-5665 ~ FAX (208) 756-5830

## **Student Job Shadowing Program**

**Mission Statement** - *To deliver compassionate Healthcare*

**Vision** - *SMMC is driven by a vision of service and organizational excellence. In achieving this vision, SMMC will be the first choice for healthcare services for the residents and visitors of the Salmon/Lemhi Valleys and surrounding areas.*

The Shadowing Program is intended for those who have an interest in healthcare. Shadowing allows the participant to follow and observe a medical professional as they carry out their job responsibilities at Steele Memorial Medical Center (SMMC).

Participants must be at least 16 years of age and enrolled in related high school or college courses or be an adult who has expressed interest in a career change to healthcare. Requirements of paperwork, TB results and MMR immunization records must be completed and submitted to the Human Resources Department. Human Resources will review and consider all applications. Once an application has been approved, Human Resources will then contact the shadowing applicant with the date and time that has been approved for shadowing. Response time for this process may vary depending on the department's availability and program demands.

All students are required to acknowledge and follow the procedures outlined in the Student Job Shadowing Program.

### **1. Goals of the Student Shadowing Program**

- a. Encourage students' exploration and interest in the healthcare industry
- b. Assist students in making future career decisions
- c. Increase students understanding of how personal and professional interests potentially match the career opportunities that Steele Memorial Medical Center and other healthcare facilities have to offer
- d. Demonstrate to students that healthcare provides a great environment to work.

### **2. Eligibility & Responsibility Requirements**

- a. Students must be at least 16 years of age.
- b. Students under the age of 18 require the written consent of a parent/legal guardian on all forms to participate.
- c. Shadowing experiences are not meant to be formal educational experiences. This is an observation and information experience only.
- d. A student who is shadowing may not scrub in surgical cases, write on charts, or actively participate in patient care.
- e. Students are expected to conduct themselves in a professional manner at all times while at Steele Memorial Medical Center or Steele Memorial Clinic. Behavior problems or problems with students attempting to function outside their scope of practice are to be reported promptly to the Human Resources department.
- f. Maintain confidentiality requirements at all times. Information about patients, employees or volunteer staff of Steele Memorial Medical Center must be treated as confidential.



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### 3. **Application Process**

a. Students must complete and return the attached Student Job Shadow Information packet to:

**Attn: Human Resources Department**

**Steele Memorial Medical Center**

**203 S. Daisy St.**

**Salmon, ID 83467**

b. Incomplete applications will not be processed.

c. Please allow at least two weeks' notice to process all appropriate paperwork.

d. For any questions regarding the status of your application, please call Human Resources at (208) 756-5665



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## STUDENT JOB SHADOWING INFORMATION PACKET CHECKLIST

Please return the following completed forms:

_____ Acknowledgement	Read and sign
_____ Student Job Shadowing Application	Read and sign
_____ Student Job Shadowing Agreement	Read and sign
_____ HIPAA Privacy, Security and Confidentiality Agreement	Read and sign
_____ “HIPAA: Privacy Compliance” video (or provide transcript verifying HIPAA training)	Watch, Read & Sign (or Provide Copy)
_____ Volunteer Release of Liability Agreement	Read and sign
_____ Compliance Code of Conduct	Read and sign
_____ Dress Code Policy/Professional Appearance	Read and initial
_____ Background check completed within the last 12 months	Provide Copy or Inform HR that you will need a Background check
_____ Tuberculosis (TB) Test within the last 12 months	Provide Copy
_____ Measles, Mumps & Rubella (MMR) Immunization Records	Provide Copy
_____ Driver’s License or School Identification Card	Provide Copy



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## **PART 1: Acknowledgement**

The following regulations apply: Please read and initial.

- A. \_\_\_\_\_ SMMC reserves the right to a pre-screening process to determine eligibility to participate in the shadowing program.
- B. \_\_\_\_\_ Shadowing is a voluntary opportunity for which there will be no monetary compensation.
- C. \_\_\_\_\_ I am 16 years of age or older, enrolled in high school, home-schooling, college courses, or be an adult who has expressed interest in a career change to healthcare.
- D. \_\_\_\_\_ I have reviewed and completed the SMMC Student Job Shadow Information packet, including:
- Student Job Shadowing Application
  - Student Job Shadowing Agreement
  - Copy of Driver's License or School Identification Card
  - Background check (completed within the last 12 months)
  - Copy of Tuberculosis (TB) Test within the last 12 months
  - Copy of Measles, Mumps & Rubella (MMR) Immunization Records
  - HIPAA Privacy, Security and Confidentiality Agreement
  - Volunteer Release of Liability Agreement
  - Compliance Code of Conduct Agreement
  - Watch "HIPAA: Privacy Compliance" video (or provide transcript verifying HIPAA training)
  - Dress Code Policy
- E. \_\_\_\_\_ I agree to maintain privacy and confidentiality of information as defined by the Organizational policies that have been provided to me prior for review as attested to above.
- F. \_\_\_\_\_ I attest that I have reviewed all of the Student Shadow written information, completely understand the contents of said documents, and fully agree to abide by the rules and regulations of Steele Memorial Medical Center.
- G. \_\_\_\_\_ The information provided is true and factual without misrepresentation. Falsification of information provided will result in rejection of the participant from the current and future student job shadowing opportunities at Steele Memorial Medical Center.
- H. \_\_\_\_\_ I understand that my application information may be shared with personnel within the Organization, who have a need to know this information for Safety and Security.
- I. \_\_\_\_\_ I understand that SMMC reserves the right to terminate a Student Job Shadowing assignment at any time, for any reason.



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Completed Job Shadow Information packet and proof of TB and MMR immunization records must be mailed to or delivered to Human Resources Department, 203 S. Daisy St., Salmon, ID 83467.

On the day of shadowing, participants will check in at the Front Desk and obtain a “Student” badge from the appropriate Department. This badge **MUST** be returned to the appropriate department at the end of day.



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## PART 2: Student Job Shadow Application

### Student Information

Full Legal Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

SCHOOL/ORGANIZATION: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Contact: \_\_\_\_\_

EMPLOYEE/PHYSICIAN Sponsor Name: \_\_\_\_\_

\*Departments of Interest / Shadowing Goal: \_\_\_\_\_

\*Preferred Observation Date(s) and Time(s): Start: \_\_\_\_\_ End: \_\_\_\_\_

### Student Emergency Contact(s):

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Participant Emergency Information: (allergies, seizures, diabetes etc.)** This is not required but recommended.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Parental Consent if student is less than 18 years of age:

Parent/Legal Guardian Printed Name: \_\_\_\_\_

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### For Office Use Only

Date Approved: \_\_\_\_\_

Application,  Agreement,  Acknowledgement,  HIPAA Form,  HIPAA Video,  Volunteer Release,  Code of Conduct,  OIG,  EPLS,  Dress Code,  TB Test,  MMR,  ID Badge



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## **PART 3: Student Job Shadow Agreement**

This Agreement reflects that Steele Memorial Medical Center (SMMC), in response to interest in a job shadowing program at its facility, desires to assist high school, college students or an adult with healthcare to discover whether they want to pursue a future career in the healthcare profession. In consideration of this, the following are conditions and terms for shadowing at our facility:

Shadowing is defined as to *follow* and *observe* a medical professional as they carry out their job responsibilities at SMMC.

Participants must be at least 16 years of age and enrolled in related high school or college courses or be an adult who has expressed interest in a career change to healthcare. Requirements of paperwork, TB results and MMR immunization records must be completed and submitted to the Human Resources Department. Human Resources will review and consider all applications. Once an application has been approved, Human Resources will then contact the shadowing applicant with the date and time that has been approved for shadowing. Response time for this process may vary depending on the department's availability and program demands. As a participant in the shadowing program, I understand and agree:

- ◆ I will not touch the patients. If I am allowed to observe a patient having a procedure, I understand the director or manager is to obtain the patient's consent first.
- ◆ I will not touch medical equipment.
- ◆ I do not have medical record or chart access and will not have computer access.
- ◆ I will not assist in feeding but may help deliver food.
- ◆ I will not approach physicians about personal illness or medications.
- ◆ I will dress professionally as outlined in the attached dress code.
- ◆ I agree to a health record review by appropriate SMMC Nursing Personnel to include proof of immunizations and a TB skin test or chest x-ray within the past year. If a TB test has not been previously completed, I understand I will obtain this before being able to shadow.
- ◆ I am subject to SMMC's drug testing policy. If I object, I will be asked to leave the premises immediately.
- ◆ I understand SMMC is not held responsible for any accident or injury that may occur on its premises while shadowing. In addition, I am to leave valuables at home and realize it is my responsibility that these items are secured prior to shadowing.
- ◆ I will not perform my own personal care in the clinical setting (i.e. applying lip gloss, handling contact lenses, eating or drinking, brushing hair, etc.)
- ◆ I will not be permitted in areas of contamination such as isolation rooms, and soiled linen areas.



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- ◆ I cannot participate in the program on days that I am ill. It is my responsibility to report to the Human Resources Department before reporting for a work assignment or with the onset of signs and symptoms consistent with illness. These include but are not limited to: fever, diarrhea, productive cough, rash, or open wound.
- ◆ I understand that I will be required to sign a HIPAA Privacy, Security, and Confidentiality Agreement wherein I agree to keep all patient information confidential.
- ◆ I understand that SMMC shall have the right to immediately terminate my participation in the program if it is determined at the manger or supervisor’s discretion that I am not acting in the best interest of the patient or facility. In addition, the director or manager holds the right to terminate shadowing at any point if deemed necessary.
- ◆ Upon arrival to SMMC, I will obtain a “Student” badge from the appropriate department and return it upon departure each day of shadowing.
- ◆ As a shadow participant, I understand my visit is limited up to 24 hours maximum per position, not to exceed 48 hours of shadowing total. If the experience needs to exceed one week, the participant must receive further approval from Human Resources. Exceptions are those in a professional college program that have required observation hours over a prolonged period of time. In this case, a school contract must be on record between the school and the hospital. The director, manager, and/or preceptor have the right to terminate shadowing at any time the need may arise.
- ◆ I will abide by the policies of Steele Memorial Medical Center and will sign the attachment statements. My signature below certifies my understanding of the information above.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

***Parental Consent if student is less than 18 years of age:***

Parent/Legal Guardian Printed Name: \_\_\_\_\_

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_





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## **PART 4: Consent Forms**

### **HIPAA PRIVACY, SECURITY and CONFIDENTIALITY AGREEMENT Job Shadow**

Name (PLEASE PRINT) \_\_\_\_\_

Information about patients, employees or volunteer staff of Steele Memorial Medical Center must be treated as confidential. It is the obligation of every employee, volunteer, professional staff member or student to maintain confidentiality.

Confidential information includes (but is not limited to) patient records and patient-related information, including financial information; employee records; any information of a private or sensitive nature; or any information whose unauthorized or indiscreet disclosure could prove harmful to a patient, employee, volunteer or Steele Memorial Medical Center.

**PLEASE READ AND INITIAL THE FOLLOWING:**

Steele Memorial Medical Center requires that all job shadows must sign the following confidentiality agreement:

- \_\_\_\_\_ I will protect the confidentiality of patient and hospital information.
- \_\_\_\_\_ I will not release unauthorized information to any source.
- \_\_\_\_\_ I will not access or attempt to access information other than that information which I have been authorized.
- \_\_\_\_\_ I will not access any computers.
- \_\_\_\_\_ I will not use another person's computer security code.
- \_\_\_\_\_ I will not fax patient information outside of the hospital.
- \_\_\_\_\_ I understand that any violation on my part of the above conditions could result in immediate termination of my job shadow.
- \_\_\_\_\_ I understand that the violation of this agreement, whether intentional or due to neglect on my part, may result in potential personal civil and criminal legal penalties.

I have read and agree to adhere to the conditions of this Confidentiality Agreement.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

***Parental Consent if student is less than 18 years of age:***

Parent/Legal Guardian Printed Name: \_\_\_\_\_

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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I \_\_\_\_\_ have watched the “HIPAA: Privacy Compliance” video and understand that I have a legal obligation to maintain patient privacy and security of protected health information (PHI) as outlined in the Health Insurance Portability and Accountability Act (HIPAA) and the Information Technology for Economic and Clinical Health Act (HITECH) as well as an ethical responsibility to protect the confidentiality and safeguard the privacy of PHI. I agree to follow all the HIPAA and HITECH rules and regulations.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



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## VOLUNTEER'S GENERAL RELEASE OF LIABILITY

For and in consideration of my being allowed to volunteer at Steele Memorial Medical Center, and in recognition of my own personal benefit from such a volunteer program, I do hereby release Steele Memorial Medical Center, and any and all other officers, employees, volunteers, agents, insurers and any elected or appointed officials of said ENTITY, individuals or entities affiliated with such persons and/or entities, from any and all civil liability or any and all forms of injury which may arise as a result of my participation in such program.

I acknowledge that I understand that there are many known and unknown dangers and/or risks associated with me volunteering and I grant a general release, for myself, my heirs, executors, administrators and assigns and I waive, remise and forever discharge and release Steele Memorial Medical Center and any and all elected or appointed officials of said ENTITY, and all officers, employees, volunteers, agents, insurers and any other individuals or entities affiliated with such persons and/or entities from any and all claims, several or otherwise, past, present or future, which can or may ever be asserted as a result of any injuries or damages, physical or mental, sustained by me while I am participating in said program in any way, including my coming and going from such program.

I understand that this release does not waive any rights I may have under the workmen's compensation laws of the State of Idaho or any protection I may have under the Idaho Tort Claims Act; however, I also expressly understand and acknowledge that this release does not create any rights not specifically and expressly provided to me under the workmen's compensation laws or Tort Claims Act. I further understand that my participation in the aforementioned program does not create any form of employment with Steele Memorial Medical Center and does not grant me any rights that are not expressly provided for by law or contract.

I acknowledge that I am serving in a volunteer capacity for the services to be rendered and I am not entitled wages, pay or the usual benefits of employees of the ENTITY. I further represent that I am not currently employed by the ENTITY.

I have read the foregoing and understand that the terms of this agreement are contractually and legally binding and that no verbal statement to the contrary, by any person or entity, can void or alter the terms of this agreement.

DATED This \_\_\_\_ day of \_\_\_\_\_, 20\_\_

Printed Name:

\_\_\_\_\_

VOLUNTEER:

\_\_\_\_\_

*(Signature)*

WITNESS:

\_\_\_\_\_

*(Signature)*



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## **Steele Memorial Medical Center Compliance Code of Conduct Employee, Provider & Volunteer Agreement**

### **Compliance Statement:**

Each employee, provider and volunteer performs within the prescribed limits of Steele Memorial Medical Center hospital/department compliance and ethics program. Each employee, provider and volunteer is also responsible to observe and report compliance variances to their immediate supervisor or follow the chain of command and report it to the Steele Memorial Medical Center Compliance Officer, Compliance Committee, or the Compliance Hotline.

I have read and understand the Steele Memorial Medical Center (SMMC) Compliance Code of Conduct Policy. I will adhere to all guidelines; SMMC, Federal, State, and Local and understand that I will be held accountable for behaving in a manner consistent with the Compliance Code of Conduct.

Name (Printed): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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## **PART 5: Job Shadow Professional Appearance**

Steele Memorial Medical Center strives to assure that all employees, students, and volunteers present a professional, business-like appearance that projects competency, inspires confidence, communicates respect to patients and the public, and provides for safety and infection control. Medical staff dress code is addressed separately in the Provider Code of Conduct.

The following guidelines apply to all job shadow participants. As indicated, patient care/clinical staff (staff whose primary job involves work in a patient care area) have more specific guidelines for safety. A Department Manager may further define appropriate standards of appearance to meet particular and/or unique circumstances in their department or unit.

### **Dress Code Policy 750-025**

*General Guidelines apply to all employees on duty:*

1. Good personal hygiene is required of all employees.
2. Employees are responsible for wearing their Steele Memorial ID badge at all times while on duty. ID badges must be worn in visible manner, above the waist line.
3. Excessive use of cosmetics, perfume/aftershave is inappropriate. The use of Perfume/Aftershave is inappropriate in Patient Care areas as it can be offensive to patients.
4. Hair and nails must be clean, well groomed and properly trimmed. *In all direct patient care areas (including dietary, lab, radiology, all nursing units, clinic, rehab, environmental services),* hair longer than shoulder length must be pulled back, restrained, or braided.
5. Artificial nails (including acrylic) **are not allowed** for **any** direct patient care provider (*including dietary, lab, radiology, all nursing units, clinic, rehab, environmental services*).
6. Beards are permitted, but must be kept neat, clean, and trimmed.
7. Body piercing paraphernalia of any kind, with the exception of earrings (maximum (2)/ear), is not appropriate to the work setting. Earrings must be professional in appearance.
8. Jewelry, on nursing units:
  - Chains – worn inside the top.
  - Earrings – small, professional, and appropriate for professional area.
  - Wrist jewelry – wrist watch and/or medical alert band/*bracelet (1)*, only.
  - Hand Jewelry – two rings maximum.
9. Visible tattoos and/or hickies must be covered unless absolutely impossible to do so (i.e. tattoo on leg must be covered with cosmetics or clothing).
10. Proper undergarments must be worn at all times and must not be visible.
11. Clothing/uniforms must be neat, clean, wrinkle-free and in good repair. Uniforms must be dresses, *pants*, skirts, *and/or* scrubs, dependent upon the uniform of the department. All clothing is to be in good condition; not torn, ripped, patched, tight fitting, or excessively worn.



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12. Underarms are not to be visible (example; no sleeveless attire). Short sleeves or cap sleeves are permissible.
13. Cleavage is not to be visible at any time (example; when bending over), wear an undershirt if needed.
14. Denim blue jeans are not permitted (exception: lab and radiology staff coming back on call should put on a lab jacket over blue jeans). Black or colored jeans may be worn if approved by the department manager. *Non-patient care areas addressing on call situations may be permitted to wear appropriate jeans as defined above.*
15. Capri pants are not permitted in the workplace.
16. ALL footwear must be professional in appearance, clean, and well maintained. Open toed shoes or sandals are not permitted on the Nursing units, Lab, Radiology, Housekeeping, Engineering, Dietary or in the Laundry. Hosiery/socks must be worn by all employees. Safety, comfort and appearance are the main consideration for acceptable footwear.
17. Only naturally occurring hair color is allowed. Unacceptable: green, blue, pink, etc.
18. Hats are not to be worn in the building while on duty except when required for infection control or health codes.

**Examples:** These examples are not intended to be all inclusive. Professional, business-like attire will ultimately be determined at the discretion of the department manager/director.

**MEN:**            Appropriate: Dress slacks; shirts with buttons, collars and sleeves.

Inappropriate: Bib overalls, sweatpants; T-shirts with logo, sweatshirts, tank tops.

**WOMEN:**       Appropriate: Skirts and dresses no shorter than 3” above the knee and slits no more than 3” above the knee; conservative in fashion and skirts worn in combination with coordinated tops; dress slacks; dress tops, knit tops, blouses, sweaters, blazers.

Inappropriate: Skorts, culottes, walking shorts, leather, form-fitting, leggings, pajama-like attire. Capri’s, bib overalls, sweatpants, low-rise pants; T-shirts, sleeveless shirts or dresses, sweatshirts, tank tops, clothing made of sheer material, form-fitting tops, tops that expose the mid-rift at any time (i.e. when reaching or bending over).



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\*\* You are expected to check with your Sponsor or Department Manager about specific appearance standards for your department or unit. Any clothing and/or accessories (including jewelry) that interfere with patient care and/or your ability to effectively perform work duties are prohibited. Sponsors or Department Managers have the authority to address your appearance. If you dress inappropriately, you will be asked to leave and return in appropriate attire.

INITIAL AND DATE: \_\_\_\_\_

## **Identification Badges**

The Hospital identification badge must be worn above the waist. Your identifying information must be visible at all times. The badge may not be altered or have anything affixed that would prohibit proper function. Your badge must be in your possession at all times for the purpose of time recording and identification in the case of an emergency and/or disaster. If your identification badge is lost or stolen, you must report it to the Human Resources Department immediately. If your badge is lost, there will be a replacement charge.

INITIAL AND DATE: \_\_\_\_\_