



**CONFIDENTIALITY ACKNOWLEDGEMENT FORM  
FOR SHADOWING/OBSERVATIONAL EXPERIENCES**

When you participate in a shadowing or observational experience at Bellin Health, you are involved in a unique experience. You will be shadowing a healthcare professional for a specified period in a healthcare facility. During this time you will or may be seeing patients with a variety of medical issues and/or you may see and hear confidential information relating to these patients.

**It is against the law to disclose:** Individually identifiable patient information that is transmitted electronically, maintained in any electronic medium, or transmitted or maintained in any other form or medium (including written or oral communication). This relates to information about past, present and future:

- Physical and mental health;
- Provision of health care to the patient; and
- Payment for the patient’s health care.

As a condition of participating in this shadowing/observational experience, I understand and agree:

1. That everything about a patient’s health care is confidential.
2. To not discuss this confidential patient information with anyone except the health care professional that I am shadowing. I am welcome to ask the health care professional questions during this program, but I may not disclose this information to anyone else.
3. To not access protected or confidential information.
4. To abide by the dress code as directed by the department contact person.
5. To use proper language and a respectful manner at all times.
6. To seek out and follow the directions of the supervising person/person in charge, especially in any code situations and in the case of other safety or procedural questions.

\_\_\_\_\_  
Print or Type Name

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

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone Number(s): Home = \_\_\_\_\_ Cell = \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**To be completed by Bellin Staff:**

Clinical Area/Department of Shadow/Observation: \_\_\_\_\_

**Date(s)/Time(s) of Shadow/Observation** (must be completed or form will be returned):  
\_\_\_\_\_

Bellin Clinician Supervising Student On-site (First and Last Name): \_\_\_\_\_

**Immunization/Vaccination History Requirement Verification (Observer must submit official documentation providing proof of vaccination; DO NOT ONLY PROVIDE DATES):**

MMR vaccine/titer date: \_\_\_\_\_ Flu vaccine date: \_\_\_\_\_ Flu Vaccine Declination: \_\_\_\_\_

COVID Vaccination date: \_\_\_\_\_ or COVID Vaccine Declination: \_\_\_\_\_

Flu vaccination is required for ALL observations during flu season (generally November 1 – March 31).