SOUTHWELL

Orientation Checklist for Short Term Shadow Experiences

Full Name (please print) _____

Date of Experience: _____ **Area of Experience:** _____

INITIALS	TOPIC
	Copy of Driver's License/Student ID
	Student Shadowing Overview Packet
	Signed HIPAA Verification Form

As a Short Term Shadow for the Tift Regional Health System, Inc, I agree to comply with the guidelines addressed in this training. My initials on this form indicate my receipt and acknowledgement of information related to each topic listed above.

_____ _____

Signature **Date**

FOR HR USE ONLY

	Completed Immunizations (2 MMR, 2 Varicella, 3 Hep B, TD/Tdap) (Cleared by EH)
	TB Skin Test (Cleared by EH)
	Flu Vaccine/Exempation (Cleared by EH)
	COVID Vaccine/Waiver (Cleared by EH)
	Add to Spreadsheet
	Email Manager

_____ _____

HR Representative Signature **Date**