Dear Shadow applicant:

Thank you for your interest in the shadow program at Carolinas HealthCare System - Lincoln. The shadow program will be a richly rewarding experience for you. **A shadow placement is described as an opportunity to “shadow” a healthcare professional no more than 16 hours.** At Carolinas HealthCare System - Lincoln, you will find challenging activities that will be satisfying to you and valuable to your educational experience.

In keeping with the quality care tradition of Carolinas HealthCare System, we are committed to creating and maintaining excellence in all that we do. Enclosed is your shadow application. Please complete the application and return to the Volunteer Services office.

Please return the application to:

Carolinas HealthCare System - Lincoln  
Volunteer Services  
PO Box 677  
Lincolnton, NC 28093  
Fax: 980-212-6060

Sincerely,

Volunteer Services  
(980) 212-6041

Enclosures
Carolinias HealthCare System  
433 McAlister Road  
Lincolnton, NC 28092

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<th>Last Name</th>
<th>First Name</th>
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<td>Home Phone</td>
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<td>Email address:</td>
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I have completed:  ____High School  ____ Some College  ____ College  ____Graduate School

**Emergency Contact Information:**

(1) Name_________________________Relationship_________________________

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(2) Name_________________________Relationship_________________________

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Are you currently a student? _______Where? __________________________

Are you currently a hospital volunteer? _______Where?___________________

Why do you wish to shadow at the hospital?  (If for a particular project, please explain.)

________________________________________________________________________

What position do you wish to observe? _________________________________

Date service must be completed? _________________________________

When are you available to shadow?  Days ___________ Time ___________
Carolinas HealthCare System - Lincoln
Shadow Agreement

HIPAA Confidentiality Statement

As a shadow at Carolinas HealthCare System - Lincoln you may come into contact with patient information in the form of electronic, written, and/or oral means. All Patient information must be considered highly confidential.

As a shadow, you will consider all information that you hear or see, either directly or indirectly, concerning a patient, patient family member, doctor, or other health care professional as confidential. You will not seek information from any of the above in regard to the patient.

You will not seek information regarding personnel employed by the hospital unless this information is normally communicated as a part of your shadow experience and is in accordance with hospital policy.

Carolinas HealthCare System - Lincoln Confidentiality Statement

As a shadow at Carolinas HealthCare System - Lincoln, I understand that:

• I may be exposed to confidential patient information in the form of written, oral, or electronic means.
• I may not disclose any information about a patient to anyone.
• The law provides for civil and criminal penalties for disclosure of confidential patient information.
• I may not reveal to anyone the name or identity of any patient.
• I may not repeat to anyone any statements or communications made by or about any patient.
• I may not reveal to anyone any information that I learn about the patient as a result of discussions with others providing care to any patient.
• I may not write or publish any articles, stories, papers or other written materials containing the names of any patient or information from which the names or identities of any patient can be discerned. If a paper is written about my shadow experience, I agree that I will submit it to Volunteer Services for approval.
• I must not ask for any specific information about a patient’s health or illness.
• I will not suggest nor offer opinions or diagnosis or methods of treatment to patients or family members.
• By signing this agreement, I assume responsibility for confidentiality of the patients, doctors, nurses and employees or Carolinas HealthCare System - Lincoln.

Signature: _________________________________  Date: __________________

As a sponsor to this shadow applicant, I agree to provide direct supervision and gain the patient’s permission to allow the shadowing individual to observe me while interacting with the patient.

Sponsor’s Signature: _______________________________ Date: ______________