Mercy Medical Explorers – Mercy Springfield

Welcome to the Mercy Medical Explorers Program! Please complete the attached application form and email it to SPRGMedicalExplorers@mercy.net once completed. All application items will need to be submitted by January 8th, 2025. The table listed below is a guide for you to showcase all the materials needed to be a part of Mercy Springfield's Medical Explorers program.

APPLICATION DUE DATE: JANUARY 8th, 2025

APPLICATION CHECKLIST

Completed before Orientation	COMPLETED
1. Verification of Online Registration and Payment	
2. Exploring Youth Application	
3. Mercy Medical Explorer Application Form	
a. Career Exploration Essay	
b. Release of Responsibility	
c. Job Shadow Agreement	
d. Clinical Pathway Survey	
e. Badge Form & Photo	
f. Scrub Sizing Form	
g. Student/Shadow Vaccination Verification Form	
h. Parental Permission Form	
4. One Letter of Recommendation	
Completed during Orientation: January 13th	
1. Attendance Documentation	
2. HIPAA Education Compliance	
3. Clinical Placement Background/Tour	
4. Media Consent Form	

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INFORMATION

ORIENTATION

Monday – January 13, 2025
5:30pm – 7:30pm (Please eat before attending)
Mercy Hospital - Springfield Campus
Hammons Heart Auditorium

MEETING DATES

Monday – February 10, 2025
5:30pm-7:30pm
Hammons Heart Auditorium

Monday – March 10, 2025
5:30pm-7:30pm
Hammons Heart Auditorium

Monday – April 14, 2025
5:30pm-7:30pm
Hammons Heart Auditorium

Monday – May 12, 2025
5:30pm-7:30pm
Hammons Heart Auditorium

ATTIRE

All Medical Explorers are required to wear their teal scrubs to each scheduled shadow and may also wear them to meetings. Scrubs will be handed out on orientation night- the scrubs ordering form is located on page 11 of the application packet.

PAYMENT

A payment of **$80** is required for new Medical Explorers. **Membership is valid for 12 months following entrance into the program)**.

You can pay using the following link:

Mercy Medical Explorers Registration Fall 2024 (onlineregistrationcenter.com)

(If link does not work, copy and paste into search bar):
https://www.onlineregistrationcenter.com/SPRGMedicalExplorers

EXPLORER NAME (please print)

_____

☐New Explorer	☐Renewing Explorer - INITIAL Date joined (Month/ Year)_____	
Personal Information		
Name:	**Birth Date:**	
Address:	**City/ State:**	**ZIP:**
Cell Phone:	**Emergency Contact Phone:**	
Email address:		
Parent/guardian Names:		
Relative employed at Mercy?	**Job Title:**	**Department:**
Education Information		
School:	**Grade:**	
Honors/Organizations/School Activities:		
Volunteer activities:		
Special interest in healthcare:		
Would you like to be a Mercy-Springfield Medical Explorer Executive Committee member?		
References		
Attached is one recommendation letter to be completed by a teacher and/or one other person outside of your school (clergy, group leader, coach, etc.) **Reference will email the completed form to SPRGMedicalExplorers@mercy.net**		
Applicant's Statement		
I hereby state that all the information that I provide on this application is true and accurate. I understand that if I am accepted and any such information is later found to be false in any respect, I may be dismissed from the Mercy-Springfield Medical Explorer Program.		
Signature	**Date**	

Essay (typed or printed)

Please write a brief (200 words) essay on your interest in a healthcare field and why you would like to be considered for the Mercy-Springfield Medical Explorer Program.

Include answers to the following questions:

- Why are you interested in a healthcare career?
- What is your area(s) of interest in healthcare?

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Release of Responsibility

The Mercy-Springfield Medical Explorers program is a voluntary program designed to introduce participants to a variety of medical situations. Participants are responsible for their own well-being, including hydration, eating of meals, wearing appropriate clothing, and acting in a reasonable and appropriate manner. Participants are financially responsible for any injury or harm to the explorer resulting from their own actions which caused or contributed to the injury or harm.

Mercy-Springfield Hospital is not responsible for accidents which occur due to a participant's own actions and will not be held financially liable for these situations. The undersigned hereby holds harmless Mercy-Springfield Hospital, its agents, employees, successors, heirs, executors, administrators and all parent and subsidiary corporations from all claims and demands of any nature, causes of action, and any liability resulting from personal injury and consequences thereof, while participating in the Medical Explorers program with Mercy-Springfield Hospital.

Mercy- Springfield is not held financially liable for required seasonal vaccinations or additional lab testing if requested by Mercy Coworker Health Services.

Medical Explorer: _____

(Please print)

Signature: _____ Date _____

Parent / Guardian Signature:

_____ Date _____

(Required if you are considered a dependent and / or covered by insurance through parent/guardian.)

Parent / Guardian Contact Phone (required) _____

JOB SHADOW AGREEMENT

I understand and acknowledge that Mercy Health ("Mercy") has agreed to allow me to shadow professionals at its facility based on my interest in exploring a potential career in the health care field. In consideration of Mercy allowing me the opportunity to participate in its observational learning / job shadow program, I understand and agree as follows:

1. Shadowing is limited to following and observing a medical professional as they perform their job duties at Mercy. I will not have unsupervised access to patients.

2. While on Mercy premises, I will abide by all policies, rules and regulations of Mercy and follow the direction of the Mercy co-worker to whom I am assigned for the job shadow program.

3. I understand and agree that photography is not permitted at any time during the job shadow program.

4. My required immunizations are current. I have not had any exposure to measles, rubella or chickenpox in the last 30 days.

5. I understand that as an observer, regardless of background and training, I may not perform any medical procedures. I will not physically touch patients. If I am allowed to observe a patient during a procedure, I understand the healthcare professional is to obtain the patient's consent first.

6. I will not touch medical equipment.

7. I will not access Mercy medical records, charts or computers.

8. I will not assist in feeding but may help deliver food to patients.

9. I understand that as an observer, I may not approach physicians or other Mercy health care professionals about my own personal illness(es) or medications.

10. I will dress professionally as outlined in the attached dress code policy.

11. 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.).

12. I will not be permitted in areas of contamination such as isolation rooms, soiled linen areas, lab, and autopsy rooms. Isolation rooms will be clearly marked with signage outside of the patient room indicating the type of precautions.

13. I will abide by Mercy's Infection Prevention policies and will not participate in the shadow program when I am sick, experience the onset of any signs and symptoms consistent with illness, and/or potentially have a contagious illness. Examples of symptoms that prohibit me from participating in the job shadow program include, but are not limited to: fever, diarrhea, vomiting, productive cough or sneezing, rash, or open wound.

14. I agree to release, indemnify, and hold harmless Mercy and its officers, agents, co-workers, attorneys, subsidiaries, affiliated entities, predecessor and successor organizations, insurers and assigns ("Mercy Entities") from and against any and all responsibility and obligation for my participation in the job shadow program. I agree not to hold Mercy liable for any or all injuries, losses damages or expenses which may occur as a result of any act or omission of Mercy Entities, or which may arise from my participation in the job shadow program.

15. I hereby authorize Mercy to provide emergency or urgent medical treatment as deemed advisable by any physician or surgeon on the professional staff of Mercy. Mercy will not be responsible for the costs of such medical treatment. I understand that this authorization is given in advance of any specific diagnosis, treatment or hospital care required, and that Mercy will rely on this authorization only in the event of any emergency or urgent situation. In the case of a minor student, every effort will be made to contact the parent/guardian listed prior to treatment, and the consent will only be used at a time when the parent/guardian consent may not be available.

16. As part of the job shadow program, I understand that I will be in a facility where patients are being treated. And, as a part of the job shadow program, I may come into contact with patient information. I understand that Mercy is obligated under both federal and state law to keep patient information confidential. I further understand that if I encounter patient information through the course of the job shadow program, it is solely for the purpose of demonstrating concepts of principles, and not for the purpose of disclosing the patient's information, condition, diagnosis or treatment. I understand that all information about patients, whether it is medical or personal, is absolutely confidential and I will not discuss or repeat anything that I see, read, or hear. I have read and signed a Confidentiality Agreement wherein I agree to keep all patient information confidential.

17. I understand that any fraudulent application, violation of confidentiality or any violation of the above provisions will result in the termination of my privilege to observe and participate in rounds in clinical areas and I may be subject to legal liability as well.

18. I understand that Mercy may remove me from the job shadow program for any reason, or no reason at all. This includes, but is not limited to:
    - My failure to abide by the terms of this agreement or Mercy policies;
    - My failure to act in a responsible and mature manner; or
    - If Mercy believes it is in my best interest, or the best interests of its patients or co-workers.

My signature below indicates that I have read, accept, and agree to abide by all of the terms and conditions of this Agreement and agree to be bound by it.

Signature: _____ Date: _____

Name: _____

Email: _____

Phone Number: _____

Signature of Parent/Guardian (required if participant is under age of 18): _____

Printed Parent/Guardian Name: _____

Mercy Medical Explorer
Clinical Pathway Survey

The clinical rotations areas of the hospital are divided into 4 groups - following the ancillary paths that individuals may take while they are at Mercy-Springfield. Explorers sign up for the 2-hour clinical rotations within these areas over the 4-month session. The goal is to document attendance to at least 10 clinical rotations within a session. You can only attend one clinical pathway area per session, but you can sign up for at least 3 different sessions per year. Please indicate your preference below by ranking your first choice #1, second choice #2, etc….

Name:	Email:

Please rank in order of your preference the clinical pathway you would like to be a candidate. Each Pathway will extend over 14 weeks, with variable attendance dates that you choose.
Every attempt will be made to accommodate your preference to your #1 and #2 choices.

	Surgical Track:	**Surgical ICU, Surgery Heart Lung Step-Down, Cardiac Nursing, Respiratory Therapy, Radiology**
	Medical Track:	**Medical ICU, Med/Surg Nursing, Patient - Placement/Staffing, Radiology, Respiratory Therapy**
	Neurology Track:	**Neuro Trauma ICU, Neuro Trauma Progressive Care Step-Down, Neurology Nursing, Emergency Room, Radiology**
	Ancillaries Track:	**Emergency Room, Pharmacy, Radiology, Phlebotomy, Lab, Women/Children's Nursing**

Letter of Recommendation

To Whom It May Concern:

_____is applying for membership into the Mercy Springfield Medical Explorers Program. Medical Explorers is a program that provides students interested in the healthcare field the opportunity to interact with and learn from other healthcare professionals You have been selected by the student to provide a reference. Please provide the following information:

Name: _____Contact phone number: _____

Occupation: _____

Relationship to student: _____

How long have you known this student? _____

Please rate on a scale from 1 (lowest) to 5 (highest) within the following areas:

Responsibility & Maturity	1	2	3	4	5
Eagerness to Learn	1	2	3	4	5
Effective Listening Skills	1	2	3	4	5
Interest in Healthcare	1	2	3	4	5

Why would you recommend this student for the Medical Explorers Program? (Please use the attached sheet if necessary).

Reference Signature: _____ Date: _____

Thank you for completing this reference. Please email the completed letter to SPRGMedicalExplorers@mercy.net

ALL RECOMMENDATIONS ARE KEPT CONFIDENTIAL

BADGE FORM

Preferred name (only first name will be on badge): _____

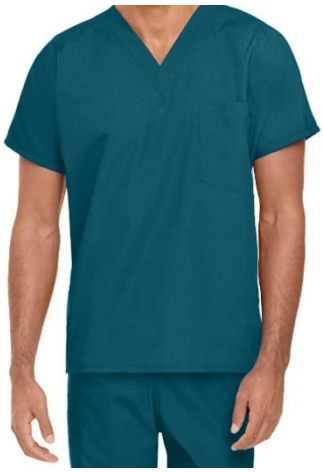
Badge photo must adhere to the following guidelines:

- Background must be white, off-white, or a neutral color.
- Photos should not be taken outside, in vehicles, in front of homes, etc.
- Nothing should be visible in the photo (e.g., no wall art, no furniture, no background, etc.); only the head and shoulders.
- No hats, caps, head scarves or large hair ornaments unless approved due to religious accommodation or part of an approved uniform.
- Use a clear image of the face with no visible tattoos.
- No filters commonly used on social media.
- No special effects on the photo.
- Clothing should be business casual/professional attire.

***Attach a copy of photo to application or paste in space below**

SCRUBS FORM

Top



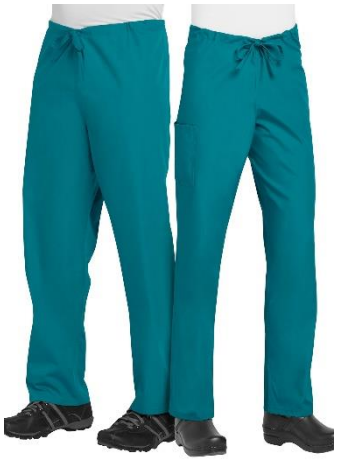
Size Guide

Size	Chest	Waist	Hip
XXS	27-29	22-24	31-33
XS	30-32	25-27	34-35
S	34-36	28-30	36-38
M	38-40	31-34	39-41
L	42-44	35-38	42-45
XL	46-48	39-42	46-49
2X	50-52	43-46	50-53
3X	54-56	47-51	54-57
4X	58-60	52-55	58-61
5X	62-64	56-60	62-65

Check the box next to your size:

☐**XXS**
☐**XS**
☐**S**
☐**M**
☐**L**
☐**XL**
☐**2X**
☐**3X**
☐**4X**
☐**5X**

Pants



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3X	54-56	47-51	54-57
4X	58-60	52-55	58-61
5X	62-64	56-60	62-65

Check the box next to your size:

☐**XXS**
☐**XS**
☐**S**
☐**M**
☐**L**
☐**XL**
☐**2X**
☐**3X**
☐**4X**
☐**5X**

Mercy Medical Explorers – Mercy Springfield

Mercy Health System Student/Shadow Vaccination Verification Form

Legal Name (Print): _____ Date of Birth: _____

The *required* immunizations MUST BE documented on this form. Signature is required by your School Nurse, Personal Physician, Nurse Practitioner or Physician Assistant to attest to accuracy.

TUBERCULOSIS SCREENING (Required)			
Two TB skin tests within the last 12 months. These are two TB skin tests with the second TST repeated 7-21 days after first TB skin test is read. **OR**		***First skin test (required)***	***Second skin test (required 1-3 weeks after first test)***
	Date Placed:		
	Date Read:		
	Induration (mm):		
	Result (Pos/Neg):		
A TB blood test **within the last 12 months (**IGRA) (T-Spot, Quantiferon Gold, etc.)	Date:		Result:
Chest x-ray - in the last two years **with** documentation of official report (for positive results only)	Date:		

REQUIRED IMMUNIZATIONS								
	Vaccinations				**Titer(s)**			
Tdap (One vaccine within the last 10 years)	Date:							
MMR Two MMR vaccinations at least 1 month apart given after age 1 ---OR--- Born prior to 1957 (exempt) ---OR--- Positive titers to Measles, Mumps, and Rubella ---OR--- Documentation of 2 Measles, 2 Mumps, and 1 Rubella vaccination	*(#1)*	AND *(#2)*	**OR**		Titer positive date: **Measles**	AND	Titer positive date: **Mumps** AND Titer positive date: **Rubella**	
Varicella (chicken pox) - Series of two doses or immunity by positive blood titer	*(#1)*	AND *(#2)*	**OR**		Titer positive date:			
Flu Vaccine (if at Mercy between October 1 - March 31) Date subject to change per CDC	Date:							
Hepatitis A (required only for students and shadowers in Daycare or Nutrition/Food Service)	N/A	**OR** *(#1)*	AND *(#2)*	**OR**	Hep A Titer Date:			

RECOMMENDED IMMUNIZATIONS				
COVID Vaccine date of INITIAL series completion:		date of LAST booster:		student declined ☐
Hepatitis B Vaccine	**Vaccinations**			**Titer**
	mo/day/year	mo/day/year	mo/day/year	Titer date/result
(Hepatitis B vaccine is a 3 vaccine series that is completed at intervals recommended by the CDC. If a negative HBsAB is found after a completed first series, a second series may be indicated. If a second negative HBsAB is resulted after a completed second series, diagnosis of non-responder.)	*1st Series*			
	(#1)	*(#2)*	*(#3)*	*Date:* *Result:*
	2nd Series (if given)			
	(#1)	*(#2)*	*(#3)*	*Date:* *Result:*

Information MUST be verified and signed by the student/shadower's School Nurse, personal Physician, Nurse Practitioner, or Physician Assistant. **Signature attests to accurate immunization documentation.**

_____ / _____

Signature (of School Nurse/Physician/Nurse Practitioner/Physician Assistant) with **Credentials** **Date:**

_____ / _____

Printed Name (of School Nurse/Physician/Nurse Practitioner/Physician Assistant) **Office Phone #:**

School or Provider Office Address/City/State: