

High School Academy for Career Exploration

Guidance Counselors Edition





Table of Contents

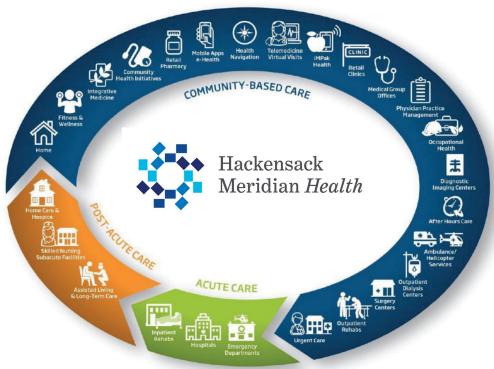
HMH Career Exploration Program Overview	
About Hackensack Meridian Health	2
Overview	4
Program Description	5
Career Exploration Application Process	7
Role & Responsibilities	8
Appendix	
Application	
Student Application	i
Parent Form	ii
Health Questionnaire	iii
Health Clearance Attestation	iv



 $\begin{array}{c} {\it Hackensack\ Meridian\ Health} \\ {\it High\ School\ Academy} \end{array}$

About Hackensack Meridian Health









4 hospitals ranked

in Top 10 in NJ







Members















50 BEST HOSPITALS



Net Revenue





Our Partners



Overview

The Hackensack Meridian *Health* H.S. Academy for Career Exploration will expose high school students to various opportunities in the *health* care industry. It will also provide experiential learning opportunities to develop transferable skills and real-world experience while in the health care environment.

The Objective

- Experience "a day in the life" of talented professionals in a workplace environment
- Gain self-confidence in selecting future career choices
- Develop a clear understanding of the various roles in health care

Program Description

The program commences Junior year with an onboarding ceremony and will continue through the student's senior year and end with a graduation ceremony. There are four phases to the program which include:

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Junior year – phase 1 – Orientation & Exploration
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Junior year – phase 2 – Mentorship Selection

Senior year – phase 3 – Internship & Project Planning [in selected area]

Senior year – phase 4 – Project Presentation

Explore Career Paths

The exploration phase one will take place over the course of the initial 4 weeks of the program during the Junior year. One day per week the student will attend a presentation by various mentors/leaders from several disciplines*. Each mentor will explain their role in the hospital setting, career options in their area and, educational requirements for specific career paths. After each presentation, the student will tour the area and further explore the operations of the department.

*Disciplines include but are not limited to:

Clinical Operations: Diagnostics Imaging, Pharmacy, Lab, Research, Surgical Methodology

Technical & General Operations: Information Technology, Central Processing, Plant Operations

Administrative: Medical Records, Finance.

Vocational: Rehabilitation Therapist, Food & Nutrition, Security

Program Description

JUNIOR YEAR

Orientation & Exploration

Phase one of the program will take place for four hours, one day per week for a duration of four weeks. Students will rotate among 12 clinical and non-clinical departments within the organization. During each rotation, a tour of the department will be given as well as additional information and career options within the department.

Mentorship

At the end of phase one, the student will select a career path to further explore and will be assigned to a trained mentor who will support the student through the remainder of the program. The mentors' role and responsibilities include but are not limited to:

- Establish the schedule
- Complete evaluations
- Provide opportunities to explore different career paths
- Support learning and project planning
- Assign tasks within scope

SENIOR YEAR

Internship & Project Planning

The student will intern within the department where the student is receiving mentorship. The mentor and student will agree on scheduled check-ins. During the internship phase, the student can observe the multiple roles and responsibilities within the department to determine a project opportunity. Once a project has been selected, the student must present to their counselor and mentor for approval or adjustments. Students will be expected to complete a total of 4 hours per week until a total minimum of 32 hours have been completed.

Project & Presentation

The project will be implemented with the support of the mentor. At the end of this phase, the student will present their project and will have successfully completed the program.

Eligibility Requirements

The student is expected to partner with their guidance counselor to insure the below requirements are met:

- Letter of Recommendation from Teacher/Advisor
- Essay on career interest (approximately 300 500 words) explaining why the student would like to join the Exploration Program at Hackensack Meridian Health
- Respectable attendance record
- Transcripts of high school career up to date

Documents/Forms:

- Health Clearance Attestation Form
- Parental Consent Form
- Confidentiality Statement

Counselor's Expected Roles & Responsibilities:

The Academy will accept a select number of students per year. An annual letter will be provided to the counselor with the application and document due dates, as well as, the number of positions available. All documents and attestations must be submitted by no later than the due date provided in the "accepting applications" letter. Please note, no late applications will be accepted.

The application will be divided into two parts. The counselor will be expected to maintain Part A on file in the school to protect the student's privacy and any HIPAA laws. Part B will be submitted to the hospital including documentation that Part A is complete and maintained at the hospital.

Career Exploration Application Process

The Student Application contains the following documents/requests.

Counselor to Keep on File:

- Health Questionnaire that needs to be signed by the student's physician
- TB Testing Instructions (Please review carefully)
- Flu Vaccination Declaration Form (during Flu season)
- Student Evaluation Form
- Parental Permission

Return to Hackensack Meridian Health

- Letter of recommendation
- Letter of attestation from the counselor agreeing that all required documentation have been successfully completed and all requirements are met.
- Essay
 to be shared with the mentor

High School Academy for Career Exploration Contact Information

- Orientation, Exploration & Mentorship Nicole Hardy, Academic Relations HSAcademy@hackensackmeridian.org
- Project Planning Support assigned mentor and counselor

Role & Responsibilities

Hackensack Meridian *Health* agrees to:

- **A.** Provide the School with use of its facilities for field experience of its students during the scheduled Program days, provided that Hackensack Meridian *Health* indicates there is a space available for the student during the application semester.
- **B.** Provide a conference room or rooms, if applicable and if available, for use by the School in conjunction with the Program during the scheduled Program days.
- **C.** Provide access to students and the School faculty designated areas of Hackensack Meridian *Health* for parking during the scheduled Program days, as applicable.
- **D.** Upon request, provide the School with a set of applicable policies, standards and procedures of Hackensack Meridian *Health*, together with all the amendments as may be promulgated from time to time.
- **E.** Upon request, designate a representative of Hackensack Meridian *Health's* administration to work jointly with the administration of the School to serve in a liaison capacity with the School faculty.
- **F.** Provide to School, upon request, a Certificate of Insurance evidencing the maintaining of (1) comprehensive liability insurance with limits of not less than One Million (\$1,000,000) Dollars per occurrence and One Million (\$1,000,000) Dollars in the annual aggregate, and (2) property damages of not less than One Million (\$1,000,000) Dollars. Hackensack Meridian *Health* may satisfy the obligations contained in this section through a funded self insurance program.

The School agrees to:

- A. Assume full responsibility for the planning and execution of the educational Program.
- **B.** Plan hours, days, and place of assignment of students in cooperation with the designated representative of Hackensack Meridian *Health* where applicable.
- **C.** Provide practical instruction to students prior to their Program assignments at Hackensack Meridian *Health* as is appropriate.
- **D.** Partner with Hackensack Meridian *Health* to coordinate Program experience for students. A summary of students assigned to Hackensack Meridian *Health* shall be provided to Hackensack Meridian *Health* along with objectives for the Program prior to each at Hackensack Meridian *Health*.
- **E.** Maintain consistent communication with Hackensack Meridian *Health* regarding student performance and evaluation, absences and assignments of students, and other pertinent information as is appropriate.

- **F.** Select qualified students for the Program and provide Hackensack Meridian *Health* with the names of the students attending, and the time and dates upon which they will be attending at least ten (10) days prior to their attendance of Hackensack Meridian *Health*.
- **G.** Require all students and instructional staff members of the School to comply with all policies, standards and procedures of Hackensack Meridian *Health*.
- **H.** Require that each student is personally responsible for his/her own *health* insurance and payment for all *health* care provided by Hackensack Meridian *Health* to School's students even for an emergency during student's scheduled participation in the Program.
- I. Provide evidence of professional liability insurance coverage for its agents, employees and students, in the amounts of \$1,000,000 per occurrence and \$3,000,000 in the aggregate. School shall also secure and maintain at all times, for its agents and employees, workers' compensation and employers' liability insurance coverage.
- **J.** Provide to Hackensack Meridian *Health* a certificate of insurance, evidencing the maintaining of a general liability insurance policy with limits of not less than \$1,000,000 per occurrence, and \$1,000,000 annual aggregate for its agents, students and employees.
- K. Prior to the start of each Program phase, the school shall present Hackensack Meridian Health evidence of the aforementioned insurance coverage and evidence that such coverage may not be cancelled to materially changed without thirty (30) days prior written notice to Hackensack Meridian Health. All insurance required hereunder shall be deemed primary insurance and shall not be deemed excess to any insurance now in effect or in the future which covers Hackensack Meridian Health, its facilities, its agents or employers.
- L. Designate, in consultation with Hackensack Meridian *Health*, technical experiences to be assigned for student learning. School shall be responsible for the supervision of students and their performance at Hackensack Meridian *Health* unless otherwise specified or agreed upon.
- M. Require that the students comply with the rules and regulations of Hackensack Meridian *Health* and to respect the right of privacy and confidentiality of the patients, personnel, and all medical records which they are exposed. Any violation of this confidentiality by a student OR INSTRUCTOR shall be sufficient cause to have that person removed from participation in the Program and may result in potential liability for the violation of the patient's right to confidentiality. Each student shall sign a Confidentiality Statement.

- N. Provide to Hackensack Meridian *Health* confirmation of immunization and training records for each faculty member and student who participates in the Program under this agreement. The School will assure that students and instructors have met the medical clearance requirements of Hackensack Meridian *Health* prior to participation in the Program. All students and faculty members shall have a medical examination according to policies established by New Jersey and federal law, and the policies, standards and procedures of Hackensack Meridian *Health*. School shall provide follow up care and counseling for students/faculty following accidental exposure to bloodborne pathogens.
- O. Withdraw from the Program any student or instructor whose performance does not comply with the School standards in the mutually agreed upon judgement of the School and Hackensack Meridian *Health* or, on the sole judgement of Hackensack Meridian *Health*, fails to comply with the policies, standards and procedures of Hackensack Meridian *Health*.
- P. Require the students to wear the uniform of the School or clothing deemed appropriate by Hackensack Meridian *Health* while on Hackensack Meridian *Health* premises.
- **Q.** Provide to Hackensack Meridian *Health* any incident reports or records relating to patient care and student education and experience.
- **R.** Provide to Hackensack Meridian *Health* any written advisements as to student performance, assignment and absences, as necessary.
- **S.** Support student and parent participation in an Orientation ("Orientation") which will be provided to all Program participants, parents and mentors, led by Hackensack Meridian *Health*'s Human Resources Policy, at the beginning of the Program.
- T. Student Criminal Background Check. Standard HR 1.2 promulgated in 2004 by the Joint Commission in the Comprehensive Accreditation Manual for Hospitals: Official Handbook, requires hospitals to verify the criminal background for students and volunteers as well as hospital staff. Pursuant to Standard HR.1.20 and the accompanying Rationale for HR.1.20 and Elements of Perfomance for HR.1.20, in order for each student (and each Student Instructor) to participate in the Program at Hackensack Meridian *Health*, prior to such participation, School shall ensure that information from the criminal background of each individual is verified by Hackensack Meridian *Health* by one of the following mechanisms:

- i. School shall conduct the individual's criminal background check and shall provide Hackensack Meridian *Health* with documentation resulting from the completion of such criminal background check. If School conducts the criminal background check, School shall ensure that the following databases are searched:
 - a) Social security traces/national background data (confirms past residences)
 - b) Statewide criminal searches (for residents of NJ, the New Jersey State Police Database)
 - c) multi-state criminal databases for all states of past residences
 - d) New Jersey county criminal searches
 - e) When applicable, out of country criminal searches
- 5. Student Assignments and Rotations. Student/patient assignments and rotation schedules shall be mutually agreed upon by the School and Hackensack Meridian *Health*.
- 6. Joint Conference. During the term of this Agreement, the parties shall conduct a joint conference for the purpose of determining the effectiveness of the program and the effectiveness of the clinical experiences and to discuss ways and means by which the Program can be improved, if necessary. The date, time and place of the conference shall be mutually agreed upon by the parties.
- 7. Class Size and Availability. Each clinical program placement at Hackensack Meridian *Health* shall not exceed a student-faculty ratio as determined by Hackensack Meridian *Health* prior to the commencement of the Program. It is understood by the parties that School must confirm with Hackensack Meridian *Health* that space is available for the student(s) prior to commencement of the applicable semester.
- 8. Independent Contractor. The parties hereby acknowledge that they are independent contractors and neither party nor any of it's agents, representatives, students, servants or employees shall be considered agents, representatives, students, servants or employees of the other party. In no event shall this Agreement be construed as establishing a partnership or joint venture or similar relationship between the parties hereto. Each party shall be liable for its own debts, obligations, acts and omissions, including payment of all required withholding, social security and other taxes or benefits.
- 9. Non-Discrimination. Both parties agree that neither party shall discriminate against any individual on the grounds of race, color, creed, religion, sex, sexual preference, national origin, veteran's status, disability, or other protected class.

Appendix

PART A - CAREER EXPLORATION PROGRAM APPLICATION APPLY ONLINE AT Jobs.HackensackMeridianHealth.org/High-School-Academy

Name			
Address		StateZip_	
Phone			
Parent Information			
Parent/Guardian		Relationship	
Phone	E-Mail Address		
School Information Name			
Address	City	State Zip	
Phone	E-Mail Address		
Experience/Volunteer			
Please list your work or volunteer experience	е		
Certification All the information on this form is true and oby me on this application or any supplement			
explorers program.	,	, , ,	, ,
Signature of Applicant		Date	
Parent/Guardian		Date	
Signature of Facility Advisor		Date	
Select the location you are applying for:			
☐ Hackensack University Medical Center	☐ Bayshore Medical Center	☐ Jersey Shore University	Medical Cente
☐ Palisades Medical Center	☐ Raritan Bay Medical Center	☐ Ocean Medical Center	
☐ JFK Medical Center	☐ Riverview Medical Center	☐ Southern Ocean Medical	Center
If you have any questions, please contact: ${\bf n}$	icole.hardy@hackensackmeridian.	org.	
Counselor please keep on file.			

i

PART A - PARENTAL PERMISSION FORM FOR CAREER EXPLORATION PROGRAM

I understand that my son/daughter _____ will be participating in a Career Exploration Program at a Hackensack Meridian *Health* hospital and give my consent for him/her to do so. As a prerequisite for the program, the hospital must review his/her medical history. Hackensack Meridian *Health* relies on the information given by the applicant and will not be held responsible for omissions or mistakes. We will consider his/her application if this meets with your approval and your child is willing to comply with the following guidelines. Please sign the consent portion of the form and answer the questions below regarding your child's *health*.

- 1. Your child meets the age requirements (14-18 years). A copy of his/her birth certificate will be needed at the time of orientation or interview.
- 2. I understand and agree that the following requirements must be fulfilled for consideration in the program: completion of Health Questionnaire, a PPD and background check.
- 3. Orientation must be completed prior to service. It provides education relative to their service, which includes appropriate precautions, rules and regulations. We encourage parents to discuss and reinforce with your child the need to adhere to all hospital policies. Volunteering is a serious commitment much like that of a job. Your child must be in regular attendance.
- 4. While in the hospital, patients have certain rights one of which is the right to confidentiality. Please encourage your child to keep all information pertaining to a patient, physician, staff or the hospital confidential.
- 5. All parents are encouraged to support your child's commitment to the program and discuss any questions or concerns with the volunteer manager or coordinator.
- 6. Your child must submit a completed *health* questionnaire, and provide proof of immunity of measles, mumps, rubella, and chicken pox; a two step Tuberculin test (Mantoux, PPD) within 1 year; Influenza vaccine or consent to mandatory masking while onsite.

I hereby give permission for my son/daughter to participate in the Career Exploration Program at Hackensack Meridian *Health*. I realize the need for him/her to be dependable, courteous, mature and uphold the hospital's code of ethics. Recognizing the hospital care for the ill, the potential for exposure to communicable disease is always present for visitors, volunteers and employees. I understand the every effort is taken to minimize exposure. I realize that if my child is injured on the job, he/she needs consent for medical treatment. I also realize that my insurance will be billed first for the cost of the treatment, then the hospital will pay the remaining balance if the injury is related to the job and only if a hospital incident report is completed.*

remaining balance if the injury is related to the job and only if a	hospital incident report is completed.*
I understand and agree to the above mentioned guidelines.	
Parent or legal guardian signature	Date
*In the event that an injury does occur, every effort will be made named below.	le to contact a parent or one of the emergency contacts that are
General Health Information	
List any medical conditions that your child may have:	
Does your child have any limitations (physical, emotional) that v	ve should be aware of in order to make appropriate placement?
If so, please explain	
Child's Physician	
Phone #	
Emergency Information	
Please give us the names of two people who can be notified in	case of an emergency:
Name	Phone #

Counselor please keep on file.

Phone #___

PART A - CAREER EXPLORATION HEALTH QUESTIONNAIRE & ATTESTATION (1 of 3)

Student Information

Name			
Address	City	State	Zip
Phone	Date of Birth		
Section I: To be completed by all applicants. (For chicken answer the following questions.)	pox, rubella, rubeola and mumps, please	refer to the exposure ch	art on page 2 to
Have you ever had varicella (chicken pox)?		□ Yes	□ No
Have you ever been exposed to anyone with c	hicken pox?	□ Yes	□ No
Have you ever had a varicella titer (test)? We require that all volunteers born after December	1, 1956 provide proof of MMR vaccination.	☐ Yes	□ No
Have you ever had the MMR (measles, mump If so when?	s, rubella) vaccine?	☐ Yes	□ No
Have you ever had the German Measles (rubel	la)?	□ Yes	□ No
Have you ever been exposed to anyone with G	German Measles?	□ Yes	□ No
Have you ever had a rubella titer (test)? If yes, date and results		□ Yes	□ No
Have you ever had the Measles?		□ Yes	□ No
Have you ever been exposed to anyone with $\ensuremath{\mathrm{N}}$	Aeasles?	☐ Yes	□ No
Have you ever had a rubeola titer (test)? If yes, date and results		□ Yes	□ No
Section II: To be completed by all applicants (PPD and Hepatitis B)	5		
Have you ever had Hepatitis? If yes, date and type:		□ Yes	□ No
Have you ever been exposed to anyone with H	lepatitis B?	□ Yes	□ No
Have you ever had the Hepatitis B vaccine? If yes, what are the dates of your vaccine?		☐ Yes	□ No
Have you ever had the Hepatitis B surface anti If yes, date and type:	,	☐ Yes	□ No
Have you ever had tuberculosis (TB)? Did you receive treatment? If yes, date and type of treatment:		☐ Yes	□ No
Have you ever had exposed to anyone with TB If yes, where and when:	?	☐ Yes	□ No

CAREER EXPLORATION HEALTH QUESTIONNAIRE & ATTESTATION (3 of 3)

If yes, date and type of treatment:		
Have you ever had a Mantoux (PPD/TB screening) test? If yes, date:	□ Yes	□No
What was the result of your PPD? Negative Positive If positive have you had a recent chest x-ray? If yes what were the results? If positive, please have your physician complete a Symptom Review Sheet (This is available from the Occupational Health Department)	□ Yes	□No
Have you ever had the Tdap vaccine (Tetanus/Diphtheria/Pertussis)? If yes, what are the dates of your vaccine?	□Yes	□No
Exposure Chart for Diseases Chicken Pox - Spending time with person 4-5 days before rash appears until German Measles (Rubella) - Spending time with person 7 days before rash Measles (Rubeola) - Spending time with person 4 days before rash appears Mumps - Spending time with person 6-7 days before swollen glands appear Tuberculosis (TB) - Spending time with person with tuberculosis. Hepatitis B - Direct contact with blood or bloody fluid from an individual with	appears until 4 days after rash appear until 3 days after rash appears. until 9 days after swollen glands appe	
Influenza Declaration In response to Joint Commission guidelines, effective December 1, 2018 in the hospital setting will be required to complete this form and provide duration of the time in the hospital. Adult volunteers may receive the vac Student Interns and Juniors are responsible for receiving the vaccine thr	e proof of vaccination or wear a face ccination through Hackensack Merio	e mask for the
Received the Vaccine Administration		
☐ I received the vaccine through Hackensack Meridian <i>Health</i>		
☐ I received the vaccine outside of Hackensack Meridian <i>Health</i> and attached Office. Documentation must include a note from the provider of the vaccine and address of the provider, or a detailed receipt identifying the same information of the provider.	giving the date the vaccine was given	
Decline the Vaccine Administration		
□ Fear of Needles/Injections □ Fear of Side Effects □ Never Get Sick □ Relig	gious Reason	
☐ Severe allergic reaction after previous vaccine dose		
☐ History of Guillian-Barre Syndrome within 6 weeks after a previous influenz		
I understand that by declining the flu shot, I will need to wear a face mask at December 1st and March 31st.	all times within the hospital facility be	etween
I acknowledge that I am aware of the following facts: *Influenza is a serious respiratory disease that kills an average of 36,000 pers in the United States each year.	sons and hospitalizes more than 200,0	000 persons
*If I contract influenza, I will shed the virus for 24–48 hours before influenza influenza disease to all people with whom I come in contact or those in close		s can spread

*If I become infected with influenza, even when my symptoms are mild or non-existent, I can spread severe illness to others.
*I understand that the strains of virus that cause influenza infection change almost yearly, which is why an annual influenza vaccine

is recommended each year.

CAREER EXPLORATION HEALTH QUESTIONNAIRE & ATTESTATION (3 of 3)

- *I understand that I cannot get influenza from the influenza vaccine.
- *I understand that my decision not to be vaccinated could have potentially life-threatening consequences to myself and others with whom I have contact.

Despite the information provided I am choosing to decline influenza vaccination right now. I understand:

- *I may change my mind at any time and accept influenza vaccination, if vaccine is available.
- *I will need to notify the Volunteer Office if at a later date I do choose to receive an influenza vaccination.

I have read, fully understand and will comply with the requirements on this form.

Section III: To be completed by all applicants				
Are you currently under the care of a physician for any medical cond If yes, please indicate		□ Yes	□No	
Please list any known allergies				
Signature of Applicant	Date			
Signature of Facility Advisor	Date			
Section IV: To be completed and signed by your physician.				
I have reviewed the health history and the aforementioned Career E.	xploration Program applica	ant and the followi	ng holds true:	
This individual is free from contagious disease		□ Yes	□ No	
This individual is able to perform physical duties to tolerance		□ Yes	□ No	
Limitations				
Please list any medications that this patient is currently taking				
Doctor's Name (please print or type)				
Address				
Doctor's Signature Data				

PART B - HIGH SCHOOL ACADEMY FOR CAREER EXPLORATION

CLEARANCE ATTESTATION FORM

Date:			
Student Information			
Name Address		State	Zip
Phone	·		
Parent Information			
Parent/Guardian		Relationship)
Phone	E-Mail Address		
School Information			
Name			
Address	City	State	Zip
The above named student may participa all the following are complete:			
The above named student may participa all the following are complete: Health Clearance Attestation: Proof of Immunity for Measle Two step Tuberculin test (Mai or Chest X-ray, if positive, with	es, Mumps, Rubella, and Chicken Pox ntoux, PPD), Quantiferon gold immuminin one year Date:	High School Academy fo	
□ Two step Tuberculin test (Mal or Chest X-ray, if positive, with□ Seasonal Influenza Vaccine D	es, Mumps, Rubella, and Chicken Pox ntoux, PPD), Quantiferon gold immuminin one year Date:	High School Academy fo	
The above named student may participal all the following are complete: Health Clearance Attestation: Proof of Immunity for Measle or Chest X-ray, if positive, with Seasonal Influenza Vaccine Dollow Tdap Vaccine Yes Eligibility requirements met: Parental Consent Confidentiality statement Letter of recommendation Respectable attendance reco	es, Mumps, Rubella, and Chicken Pox ntoux, PPD), Quantiferon gold immuminin one year Date:	High School Academy fo	

Hackensack Meridian *Health* facilities.

Counselor please keep on file.