

**YOUTH OBSERVATION ACTIVITY APPLICATION (AGES 14-17)**

LAST NAME  FIRST NAME  BIRTHDATE   
ADDRESS  CITY  STATE  ZIP   
PHONE  AGE  CURRENT GRADE  SCHOOLNAME

Copy of Photo ID (Driver's license or school ID is attached):  Yes  No

Letter of character reference is attached:  Yes  No

PARENT 1 NAME  HOME PHONE  WORK PHONE   
PARENT 2 NAME  HOME PHONE  WORK PHONE

NAME OF GUARDIAN IF NOT LIVING WITH PARENT   
HOME PHONE  WORK PHONE

IN CASE OF EMERGENCY, NOTIFY (other than parent)  Phone

Do you have friends or relatives who volunteer or are employed by this health center?

If yes, please list their names, and relationship (i.e.: friend, parent, sister, etc.):

Have you volunteered at Saint Francis Health Center? Yes or No

Reason for observation experience:  Requested area of observation:

Reason for choosing Saint Francis?  Number of total hours required:

Deadline for acquiring the hours:  Requested days/dates:  Preferred time of day:

.....  
I understand that The University of Kansas Health System St. Francis Campus and the Department in which the student is observing assume no responsibility for youth while they are in the Health Center, for a youth who fails to report for a scheduled observation or who leaves the building without permission.

The undersigned parent/guardian consents to the participation by their child/ward in the observation activity at The University of Kansas Health System St. Francis Campus and to the TB skin tests required by health center policy. In addition, the undersigned parent/guardian acknowledges their receipt and understanding of the confidentiality statement appended hereto.

Signature of Parent/Guardian  Date

Signature of Observer  Date

**VACCINATION FORM FOR SHADOW OR OBSERVATION EXPERIENCE**

Name (please print):

Health Insurance Policy# (Attach copy)

Area of Observation:

Dates of Observation:

Name of SFHC staff Mentor:

Please provide the following information and proof:

<b>1. TB Testing information</b>	
<ul style="list-style-type: none"> <li>Date of last TB test (<i>must be within last 10 months</i>): <input type="text"/></li> <li>Result: <input type="text"/></li> </ul>	
<b>2. MMR history</b>	
<ul style="list-style-type: none"> <li>Dates of two (2) MMR or titres for rubella, rubeola &amp; mumps</li> <li>1. <input type="text"/></li> <li>2. <input type="text"/></li> </ul>	
<b>3. Varicella (Chicken Pox) history</b>	
<ul style="list-style-type: none"> <li>Have you had varicella (chicken pox) Yes <input type="checkbox"/> No <input type="checkbox"/></li> <li>(see below)</li> <li>If you have not had varicella provide: Proof of immunity (titer) or Proof of two (2) varivax immunizations</li> </ul>	
<b>4. Tetanus information</b>	
<ul style="list-style-type: none"> <li>Date of last tetanus shot <input type="text"/></li> </ul>	
<b>6. COVID-19 Vaccination information</b>	
<ul style="list-style-type: none"> <li>COVID-19 Vaccine 1<sup>st</sup> dose Date <input type="text"/></li> <li>COVID-19 Vaccine 2<sup>ND</sup> dose Date <input type="text"/></li> <li>COVID-19 Booster Date <input type="text"/></li> <li>Exemption ( if exemption has been granted, please provide paperwork)</li> <li>Must include in packet, copies of Covid Vaccination Card</li> </ul>	
<b>5. Flu Vaccine</b>	
<ul style="list-style-type: none"> <li>Date of Vaccine <input type="text"/></li> <li>If you have not received Hepatitis B immunizations provide date of signed declination of immunization <input type="text"/></li> </ul>	

Student Signature:

Date:

## SERVICE EXCELLENCE STANDARDS AND STANDARD GREETING

The University of Kansas Health System St. Francis Campus associates strive to provide excellent care and customer service to patients, families, visitors, physicians and fellow associates by following these Service Excellence standards.

### Service Excellence Standards:

- **Patient Centered Care**
  - I will communicate using SAINTS our standard greeting.
  - I will complete bedside shift report.
  - I will assure purposeful hourly rounding is completed.
  - I will talk with patients and guests, instead of at them, using language they understand.
  - I will be responsive in meeting our customer's needs and communicate changes.
- **Compassion**
  - I will connect to our purpose of caring for patients and guests as if they were my own family.
  - I will provide patients and guests my full attention and listen without interrupting.
  - I will interact with each patient and guest in a kind and genuine manner.
  - I will go above ordinary care to provide little things that give patients comfort, safety and reassurance.
  - I will use the power of human touch.
- **Teamwork**
  - I will engage in Senior Leader Rounding to create relationships of trust.
  - I will recognize patients and guests as part of my team and involve them in their care.
  - I will be flexible, accept additional responsibilities and assist my co-workers.
  - I will engage in a positive manner with team members and recognize them.
  - I will manage up co-workers and other departments.
- **Excellence**
  - I will anticipate patient and guest's needs and expectations.
  - I will escort patient and guests to their destinations.
  - I will be professional in my dress and communication.
  - I will seek out and continually acquire new knowledge and skills.

**Standard Greeting:** to be used in all customer service interactions (SAINTS)

- Smile – at 10 feet make eye contact and smile
- Acknowledge – greet at 5 feet (Good Morning, How can help, etc.), get at the customer's level
- Introduce self – your name, your role, what the customer can expect
- Name preference – use preferred name (if not known, ask customer); avoid negative nicknames
- Time and touch – provide time expectation/timeframe, use touch as appropriate to encounter
- Statement of appreciation – allow opportunity for questions, thank customer

I commit to apply the above service standards in all my work interactions with patients, families, visitors, physicians and fellow associates.

Print Name:  Department:   
Signature:  Date:

**ATTESTATION OF ADULT OBSERVATION APPLICATION**

\*\*\* Observer is responsible for finding a mentor and setting up shadowing and must have prior approval of mentor to shadow prior to submitting observation packet.

I  certify that the information I have given is true, correct, & complete.  
Printed name of observer

Signature of Observer

Date

*I agree to accept this observation application for shadowing experience.*

Mentor Signature/Title

Date

Manager or Director Signature/Title

Date

**Please email signed and dated applications to:**  
**[hailey.wilson@kutopeka.com](mailto:hailey.wilson@kutopeka.com)**

## Personal Reference Form

**NOTE: Your reference must be someone who is not related to you.**

I (reference)  am completing this Personal

Reference Form for (applicant) .

My address is:

My phone or cell phone number is:

**Please answer the following questions; your responses will be kept confidential.**

How long have you known him/her and in what capacity?

What can you tell us about him/her:

Describe any notable strengths:

Describe any notable weakness:

Please choose **10** traits that best describe the applicant:

- |                                      |  |  |                                      |
|--------------------------------------|--|--|--------------------------------------|
| <input type="checkbox"/> Flexible    | <input type="checkbox"/> Outspoken     | <input type="checkbox"/> Detail Oriented | <input type="checkbox"/> Creative    |
| <input type="checkbox"/> Structured  | <input type="checkbox"/> Needy         | <input type="checkbox"/> Approachable    | <input type="checkbox"/> Sociable    |
| <input type="checkbox"/> Dependable  | <input type="checkbox"/> Good listener | <input type="checkbox"/> Independent     | <input type="checkbox"/> Extrovert   |
| <input type="checkbox"/> Trustworthy | <input type="checkbox"/> Self-starter  | <input type="checkbox"/> Organized       | <input type="checkbox"/> Versatile   |
| <input type="checkbox"/> Productive  | <input type="checkbox"/> Compassionate | <input type="checkbox"/> Mechanical      | <input type="checkbox"/> Punctual    |
| <input type="checkbox"/> Controlling | <input type="checkbox"/> Disorganized  | <input type="checkbox"/> Adaptable       | <input type="checkbox"/> Considerate |
| <input type="checkbox"/> Receptive   | <input type="checkbox"/> Likes Routine | <input type="checkbox"/> Practical       | <input type="checkbox"/> Honest      |
| <input type="checkbox"/> Discouraged | <input type="checkbox"/> Questioning   | <input type="checkbox"/> Logical         | <input type="checkbox"/> Confident   |
| <input type="checkbox"/> Motivated   | <input type="checkbox"/> Good Natured  | <input type="checkbox"/> Reliable        | <input type="checkbox"/> Proud       |
| <input type="checkbox"/> Loyal       | <input type="checkbox"/> Resourceful   | <input type="checkbox"/> Non-Judgmental  | <input type="checkbox"/> Fun         |

Signature

Date

**Please return this personal reference form to: [Hailey.Wilson@kutopeka.com](mailto:Hailey.Wilson@kutopeka.com); Phone: 785-270-7656**