MOUNTAIN POINT
EQUINE HOSPITAL

Job Shadow Release form & Confidentiality Agreement

Name: _____ **DOB:** _____

Address: _____ **City:** _____ **State:** _____

Phone: ( ) - Email: _____

Dress Code & Behavior

It is our desire that your time at our facility is educational and enjoyable. As an intern/job shadow you will be representing Mountain Point Equine Hospital, PLLC through interactions with patients, and clients. You are expected to present yourself in a professional manor. Profanity or inappropriate conversations are not allowed. We expect all interns/job shadows to wear appropriate clothing for the job in which you will be doing that day. Interns should wear scrubs while doing in-clinic rotations, and barn appropriate attire for laboring work. Job shadows can wear casual dress (jeans **without** holes/patches, khakis, non-revealing shirts, no shirts with inappropriate writing or logos). Interns/job shadows are **not** allowed to wear shorts, skirts, shirts that show mid drift, or tank tops. Open toed shoes are also **strictly prohibited**. Please dress smart, pay attention to the weather for that day and dress accordingly.

I, agree that I am aware of dress code & behavior standards. I will do my best to follow the rules enforced.

Signature: _____

Medical Information

Emergency Contact:_____

Relationship:_____

Phone Number:_____

Medication(s)/Allgeries/Conditions:_____

_____

_____

_____

Medical Release

I, the undersigned (or parent/guardian), understand the nature of Mountain Point Equine Hospital's Internship/Job Shadow program and the activities involved, and state that the individual named on this form is in adequate health to perform, participate or observe the activities carried out in this program. I do ensure and guarantee to hold harmless Mountain Point Equine Hospital, PLLC, its staff, agents and representative from any responsibility for liability whatsoever resulting from the individuals' actions, activities or injury.

Signature (student) _____

Signature (Parent/Guardian if under 18) _____

Printed Name _____

Date _____

Confidentiality Agreement

I, the undersigned (or parent/guardian), acknowledge that as a result of my association with Mountain Point Equine Hospital, PLLC, may have access to confidential information of the practice, including patient identifiable protected health information. I will hold confidential all patient and practice information obtained and will not disclose any personal, medical related information, or any other confidential information to third parties during and after my time with Mountain Point Equine Hospital, PLLC. I am committed to protecting and safeguarding from any oral and written disclosure of all confidential patient practice information of which I became aware.

Signature (student) _____

Signature (Parent/Guardian if under 18) _____

Printed Name _____

Date _____