

# SamCamp 2019 Application

**Thank you for your interest in SamCamp 2019! This fun and interactive day camp is open for upcoming seventh and eighth grade students (2019-2020 academic year).** This two-day event will include hands-on stations, team building activities, facility tours, career workshops, CPR training and more!

SamCamp will be held on **Tuesday, Aug. 13 and Wednesday, Aug. 14**, from 8:30 a.m. to 4 p.m. at Samaritan North Lincoln Hospital. Students will be provided with snacks and lunch on both days as well as a T-shirt and a certificate of completion.

## INSTRUCTIONS

**1) Mail or email your completed application to:**

Samaritan Health Services  
Attn: Crystal Bowman  
3043 NE 28th St.  
Lincoln City, OR 97367

-or-

[cbowman@samhealth.org](mailto:cbowman@samhealth.org)

- 2) Call 541-557-6483 to pay the \$40 fee over the phone.**  
(Scholarships may be available based upon need; please call 541-557-6480 to discuss.)
- 3) Your enrollment will be confirmed** by Crystal Bowman, Clinical Educator at Samaritan North Lincoln Hospital, once these two steps are completed. The application deadline is **Monday, July 29**. Applications and/or payment will not be accepted after this date.

**Any questions?** Contact [cbowman@samhealth.org](mailto:cbowman@samhealth.org) or call 541-557-6480

**STUDENT INFORMATION**

Student name: \_\_\_\_\_

School &amp; grade level: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**PARENT/GUARDIAN INFORMATION**

Parent name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street or P.O. Box City State Zip

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**T-SHIRT SIZE**

Youth XS \_\_\_\_\_ Youth S \_\_\_\_\_ Youth M \_\_\_\_\_ Youth L \_\_\_\_\_ Youth XL \_\_\_\_\_

**DIETARY RESTRICTIONS/ALLERGIES?**

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, explain: \_\_\_\_\_

\_\_\_\_\_

**WHY ARE YOU INTERESTED IN A HEALTH CAREER? (for the student to complete)**

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## APPLICANT AGREEMENT

1. **Waiver of Liability.** In consideration that I am being permitted to participate in Samaritan Health Services' workforce development programs (e.g., job shadowing, observations, activities, etc.), I, the undersigned, in full recognition and appreciation of the dangers and hazards inherent in this activity, agree to assume all risks and responsibilities surrounding my participation in this activity. Further, I do for myself, my child/children, my heirs, and personal representative(s) agree to defend, hold harmless, indemnify, release, and forever discharge Samaritan Health Services, and its officers, agents, and employees from and against any and all future claims, demands, or causes of action, on account of damage to personal property, personal injury or death which may result from my participation in any Samaritan Health Services career-related program.
2. **No Cell Phones.** I understand while job shadowing at Samaritan Health Services, any usage of cellular devices is prohibited. All patient information and results must be kept confidential and may be reported only to those professionals directly involved with the patient's treatment and care. Failure to comply may result in dismissal from the site.
3. **Confidentiality.** I agree that I shall not, at any time during the job shadow or after it has concluded, divulge or convey any confidential information, trade secrets, business plans, proprietary information, knowledge, data or property related to Samaritan Health Services or any of its affiliates or patients other than that which is in the public domain, unless authorized by Samaritan Health Services in writing. This specifically means that you may not share details about the program or any patients (or their families) that you may come into contact with in any social media forum, such as Facebook, Instagram, SnapChat, etc. In the event of any violation or threatened violation of this section, Samaritan Health Services shall be entitled to immediate injunctive or other equitable relief in addition to any other remedies to which Samaritan Health Services may be entitled under law.
4. **HIPAA.** The Health Insurance Portability and Accountability Act (HIPAA) was enacted by Congress in 1996. HIPAA specifically protects the confidentiality of each individual's health information, and provides criminal penalties and fines for persons that breach that confidentiality. The job shadow program will place you in a medical environment and you will be personally responsible for complying with HIPAA; failure to do so may result in criminal prosecution. You may find more information about HIPAA and your responsibilities at [www.hhs.gov/hipaa/](http://www.hhs.gov/hipaa/).
5. **No Entitlement to Benefits or Wages.** I understand that I am not an employee of Samaritan Health Services or any of its subsidiaries or affiliates, and am not entitled to any wages or benefits, including, but not limited to: social security benefits, workers' compensation benefits, and retirement benefits.
6. **Responsibility to Cover Costs.** I understand and agree that I am solely responsible for any costs that I may incur by participating in this job shadowing program. These costs may include, but are not limited to: health screening, transportation, meals, and parking.
7. **Compliance with Law / Policies.** I understand and agree to abide by any and all applicable laws, regulations, and policies adopted by Samaritan Health Services, including the Code of Ethics.
8. **Health Insurance / Exposure to Infectious Agents.** I understand that the job shadow program will take place in a medical facility and that I may be exposed to infectious agents including bloodborne pathogens. I hereby represent and warrant that I have health insurance and agree to be liable for any charges for services I may receive related to emergency care and/or testing to determine exposure to infectious agents.
9. **Indemnification.** I agree to indemnify and hold harmless Samaritan Health Services, its subsidiaries, affiliates, officers, directors, agents, employees, and representatives ("Indemnified Parties," jointly and severally) from and against any and all liabilities or related, arising out of or in connection with the job shadow program, incurred by my wrongful acts, omissions, or misconduct. This shall be specifically construed to include, but not be limited to, any violations of the Health Insurance and Portability Act (HIPAA).
10. **Acknowledgment.** I have read the job shadowing/ observation request form for Samaritan Health Services and hereby certify that all information provided in this request is accurate, and that submission of this request does not guarantee placement into an experience. I further understand that approval and placement of an experience is at the discretion of Samaritan Health Services and may require additional health screening. Samaritan Health Services may terminate a job shadow at any time and for any reason.

**HAVING READ AND UNDERSTOOD THIS AGREEMENT, I VOLUNTARILY AND KNOWINGLY SIGN BELOW.**

Applicant Name Printed	Applicant Signature	Date
<i>(Required for minor applicants)</i>		
Parent/Guardian Name Printed	Parent/Guardian Signature	Date

**INFORMED CONSENT**  
**Photos, Interviews or Recordings for Non-Medical Use**  
**Conducted by SHS or Other External Entity**

I authorize Samaritan Health Services, Inc. (SHS) or any third party contracted by SHS to photograph, interview or videotape me or my child.

I hereby grant full permission to SHS and any of its affiliates to use either my or my child's image, videotape, audiotape or interview and name in any educational publication or advertising/marketing materials (printed or electronic). This consent also serves to waive all rights of privacy or compensation.

If I am a SHS employee, I understand that any image, interview or videotape of me may be used even if my employment with SHS ends. In addition, any use is not indicative of and will not have any effect, positive or negative, on my job performance/evaluation.

I understand that I may withdraw consent prior to the image, interview or recording use.

\_\_\_\_\_  
 Applicant Name Printed

\_\_\_\_\_  
 Parent/Guardian Name Printed

\_\_\_\_\_  
 Parent/Guardian Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Street or P.O. Box

\_\_\_\_\_  
 City

\_\_\_\_\_  
 State

\_\_\_\_\_  
 Zip

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

\_\_\_\_\_  
 Parent/Guardian Signature

\_\_\_\_\_  
 Date

For SHS Marketing Office use only:

Photo shoot ID#: \_\_\_\_\_ Photographer: \_\_\_\_\_

Photo/video shoot description and location: \_\_\_\_\_

Notes: \_\_\_\_\_

*Samaritan Health Services, Inc. includes Good Samaritan Regional Medical Center, Samaritan Albany General Hospital, Samaritan Lebanon Community Hospital, Samaritan North Lincoln Hospital, Samaritan Pacific Communities Hospital, Samaritan Health Physicians, Samaritan Health Plans, Inc., InterCommunity Health Network CCO and Wiley Creek Community.*

*Form Revision Date: 1-22-2016*