PATIENT AMBASSADOR POSITION DESCRIPTION

The patient ambassador provides guests information and supports the efforts of the floor staff.

Has knowledge of the basic workings of the floor. Demonstrates good customer service. Acts in a professional manner at all times. Will direct guests to appropriate area. Will assist in copying various paperwork as needed.

Because all information concerning patients is of a confidential nature, the volunteer will not discuss patient information with others not concerned with such information while on duty and will not discuss patient information with persons outside the hospital.

The Ambassador will take part in activities such as: reading to patients, changing television channels with remote control, communicating with patients and families, providing blankets and comfort items as needed. If patient requests any food or drink items, the nurse must first be consulted. Ambassador may participate in refreshing water pitchers, picking up and delivering food trays to patients as requested by the floor staff.

The Ambassador will not be involved in direct patient care. The Ambassador is not responsible for cleaning rooms, or assisting patients to the lavatory. The Ambassador is supervised by the department manager and reports to the Director of Mid-MO AHEC.

Education: High school or equivalent preferred

Experience: None required

Licensure, Registration, Certification: None required

Mental/Physical Requirements: Mental concentration required. Good communication and interpersonal relations skills essential. The position requires approximately 70% walking, 20% sitting, and 10% standing.

Working conditions: The ambassador will work in the hospital and walk to various departments in the hospital, all climate-controlled.

MID-MO AHEC PATIENT AMBASSADOR APPLICATION CHECKLIST

Prior to Acceptance into Program:

- ☐ Application/Availability
- ☐ Participation Agreement
- ☐ MAHEC Data Forms
- ☐ Contact Info/Medical and Liability Releases
- ☐ Confidentiality Statement
- ☐ TB Skin Test Results (obtained by student from Missouri S&T Student Health or Phelps/Maries County Health Department)
- ☐ Criminal Background Check Clearance (obtained by Mid-MO AHEC, from the Missouri Highway Patrol, fee required)
- ☐ Immunizations Record

  Evidence of rubella immunization or positive rubella titer

  Evidence of Hepatitis B vaccine or a signed waiver

After New Employee Orientation:

- ☐ Corporate Compliance and HIPAA modules online completion – Participant I.D. #99000XXXX

In order to request a letter of recommendation for your portfolio:

- ☐ A signed log of volunteer hours from your nursing supervisor, and
- ☐ A brief report/evaluation of your experiences as a Patient Ambassador

Mid-Missouri Area Health Education Center

PARTICIPATION AGREEMENT

1.0 Parties to the Agreement

This agreement is made and entered into by and between the Mid-Missouri AHEC, ____
(hereafter "healthcare facility")
and ____.
(hereafter "participant")

2.0 Purpose

The purpose of this agreement is to establish a temporary work/shadowing/volunteer site for the participant to provide a learning opportunity that will enhance health professions preparation.

3.0 Goals and Objectives

Program goals are to provide meaningful learning experiences for participants interested in healthcare careers and to nurture career interests through educational experiences. Healthcare facility and Mid-Missouri AHEC acknowledge that the experience may include shadowing, patient ambassador activities, or an internship of a clerical nature. This agreement is not intended for clinical training of health professions students.

4.0 Participant Responsibilities

As a participant of the experience at the healthcare facility, the student agrees to:

4.1 complete the scheduled experience as required;
4.2 maintain conduct which is professional with regard to spoken and written communication, behavior, punctuality, dependability, physical appearance and program etiquette;
4.3 submit a signed participation agreement, emergency contact information, signed medical and liability releases, a signed confidentiality statement, and a TB skin test or chest x-ray.
4.4 meet and comply with any and all policies and procedures of the healthcare facility, Centers for Disease Control and Occupational Safety & Health Administration (OSHA);
- **4.4.1** Experiences extending beyond three days (or 24 hours) requires additional documentation of immunizations and employee orientation.

4.5 submit MAHEC data form(s) and experience evaluation to Mid-Missouri AHEC; and
4.6 notify the healthcare provider and regional AHEC immediately, if sick or unable to shadow on a scheduled day.

5.0 Healthcare Facility Responsibilities

The healthcare facility shall:

5.1 provide required healthcare facility orientation and instruction regarding OSHA blood borne pathogens and tuberculosis regulations, Corporate Compliance, and HIPPA regulations before the experience begins, as required by the healthcare facility;
5.2 provide on-site supervision of the participant;
5.3 as needed, coordinate with Mid-Missouri AHEC and the student to ensure that student is meeting his/her responsibilities; and
5.4 complete and submit any required evaluations at the end of the experience.

6.0 Mid-Missouri AHEC Responsibilities

The Mid-Missouri AHEC shall:

6.1 coordinate/schedule the experience between the participant and the healthcare facility;
6.2 monitor participant's performance through phone calls, e-mail messages, and/or evaluation review;
6.3 maintain periodic contact with the healthcare facility and/or identified health care professional;
6.4 serve as the contact point for questions, comments, or concerns from either the shadowing site representative or the student; and
6.5 collect and maintain documentation concerning the participant in the program, the healthcare facility, and the experience in which the participant was placed.

Signed and agreed to by:

____ ____
Student Date | Parent/Guardian (if student is under 18) Date

____ ________________________
MAHEC Representative | Date

____ ________________________
Health Facility Representative | Date

Participant Name: ________________________________ Participant Birth Date: ________________________

Contact Information

In case of medical emergency, Mid-MO AHEC and/or the healthcare facility must be able to contact a parent/guardian or other emergency contact.

Parent/Guardian:

Name: ____

Address: ____

Home Phone: _______________________________________

Work: ____

Other: ____

Second Contact:

Name: ____

Relation to student: ______________________________

Home Phone: _______________________________________

Work: ____

Other: ____

Release of Liability

I hereby agree that while I am participating in any Mid-MO AHEC educational experience, the Mid-Missouri AHEC, the Missouri AHEC system, and the healthcare facility will not be held responsible for any injury or accident that might occur. Any medical expenses incurred as a result of such injury or accident will be my responsibility.

____ ____

Student Signature Date

(Parent/Guardian Signature if participant is under age 18)

Medical Release

(For participants under age 18)

I understand that in case of a medical emergency, every attempt will be made to contact me before medical action is taken. However, this document is my consent as a parent or guardian of the participant for emergency treatment or procedure necessary by the professional staff of the closest hospital available.

____ ____

Parent/Guardian Signature Date

____ ____

Insurance Company Policy Number

Mid-Missouri Area Health Education Center

ALL PARTICIPANTS
CONFIDENTIALITY STATEMENT

All information concerning patients, employees, volunteers, and other hospital business of a confidential nature must not be discussed with persons not concerned with such information, and never with persons outside the hospital.

Requests for information about patients by family members and/or friends should be directed to the nurse in charge or to the department director. Other requests are to be directed to administration.

While participating in any capacity at any healthcare facility, including Phelps County Regional Medical Center, I understand my obligation to maintain the confidentiality of patient and hospital information.

I agree not to release any information regarding patient data or hospital business to unauthorized individuals.

The release of, or misuse of, patient or hospital information, unless specifically authorized by the patient or covered by hospital policy, shall be cause for legal and/or disciplinary action, up to and including termination.

____
Printed Name

____
Signature

____
Date

____
Parent Signature required if participant is under age 18

MAHEC Patient Ambassador

MAHEC is required to report general demographic information about participants in the categories below. This data will be confidentially maintained and will be referenced periodically to evaluate the effectiveness of AHEC services and programs. We appreciate your cooperation in the completion of this form. **Please type or print clearly.** For more information, please contact the Mid-Missouri AHEC office at 573-364-4731 or e-mail jshipley@rollanet.org

PARTICIPANT INFORMATION

	☐Ms. ☐Mrs. ☐Mr. ☐Dr.		
Last 4 digits of SS#	(Check all that apply)	**Last Name, First Name, MI, (Maiden)**	**Suffix or Credential** (Jr., DO, LPN, etc.)

/ /	☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Hispanic/Latino ☐Native Hawaiian/Other Pacific Islander ☐White/Caucasian ☐Multi-Racial	☐**Male** ☐**Female**
Date of Birth: (MM/DD/YY)	**Ethnicity** (Select One)	**Gender**

( )- -	( )- -	
Phone (including area code)	**Cell/Beeper**	**E-Mail**

Current Address: (Street)	**City**	**State**	**Zip**

EDUCATION

Students:		/		☐7 ☐8 ☐9 ☐10☐11☐12 College ☐1 ☐2 ☐3 ☐4 Other
	Name of your current or last school attended	Grad Date (MM/YY)	**Degree Obtained** (BSN, MD, etc.)	**Current Year of Study**

PARTICIPANT SURVEY

Check all that apply to shadowing participant:

☐NHSC Recipient
☐Member NHSC Loan Repayment
☐PRIMO Loan
☐First in family to complete college
☐Received Financial Aid - Type:
☐English was a second language growing up
☐Qualified for free or reduced fee school lunch

Participant Survey:
Do you plan to practice in-state upon program completion/graduation?
☐Yes ☐No

Do you plan to practice in a rural setting upon program completion/graduation?
☐Yes ☐No

Check the most applicable type that describes the shadowing participant:

☐ Student, k-8
☐ Student, 9-12
☐ Student, undergrad
☐ Student, vocational school
☐ Other

SHADOWING INFORMATION

/ /	/ /		☐ ACES ☐ ACES+
Start Date (mm/dd/yy)	**End Date** (mm/dd/yy)	**Total Hours**	**Are you a participant in the ACES or ACES+ program?**

	☐Hospital ☐ Clinic ☐ Office ☐ Other (explain)
Shadowing Site Name	**Shadowing Site Type**

Site Address (Street)	**City**	**State**	**Zip**

( )- -	( )- -
Site Phone (include area code)	**Site Fax** (include area code)

	☐Male ☐Female	
Primary Preceptor's Name (Last Name, First Name)	**Gender**	**Discipline & Specialty** (see side box)

☐American Indian/Alaska Native ☐ Asian ☐Black/African American ☐Hispanic/Latino
☐Native Hawaiian/Other Pacific Islander ☐White/Caucasian ☐Multi-Racial
Ethnicity →

Preceptor Discipline (Select One)
☐Allied Health _____
(Assistant, Rehab, Techs, Nutrition, etc.)
☐Clinical Psych
☐Dental Public Health
☐Dental (D.D.S.)
☐Medicine (DO, MD)
☐Health Care Administrator
☐Advanced Practice Nurse
(CRNA, Nurse Midwives, NP, etc.)
☐Nurse, LPN ☐Nurse, RN
☐Pharmacy
☐PA
☐Public Health
☐Social Work
☐Preventive Medicine
☐Other_____

Preceptor Specialty (if applicable)
☐Fam Med ☐Gen Int Med ☐Gen Ped
☐Podiatry
☐Other_____

***** For MAHEC Staff Use Only *****

☐ ECMO X Mid-MO ☐ NEMO ☐ NWMO ☐ SEMO ☐ SWMO☐ WCMO☐ KCOM PO ☐ MU PO☐ SLU PO	
Primary Sponsoring AHEC	**AHEC Coordinator (First, Last Name)**

CRIMINAL BACKGROUND REQUEST

Print Legibly in Black Ink

First Name____________________ Middle Name ____________ Last Name__________

Maiden Name/Alias________________,_______________,________________

Date of Birth ___/___/___ Social Security # __ __ __ - __ __-__ __ __ __

Sex ☐ F ☐ M Race ______________________

Mailing Address: Street ______________ City ___________ State______ Zip ______
(No P.O. Box)

Please provide a copy of your drivers license or valid picture I.D..

Department of Motor Vehicles

State _____________________ Drivers License #_________________________

List last two Cities and States of Residence

1) City _____________ State ________ 2) City ________________ State_________

As part of the employment process, I consent to the release of my criminal background records by the Missouri State Highway Patrol, Illinois State Policy and any other agency that provides such information. I consent to your investigating and obtaining a consumer report, including motor vehicle driver's information from the Missouri Department of Revenue, solely for employment purposes. By signing this consent, I acknowledge I have received in writing Disclosure Regarding Procurement of a Consumer Report.

Signature ____Date________________________________