Respiratory Therapy Observation Form

Applicants may choose to perform <u>12 hours</u> of observation / shadow time with a licensed Registered Respiratory Therapist by the NBRC to observe the functions and responsibilities of a practicing Respiratory Therapist within the hospital setting.

Instructions:

Download and print this observation form. Present this form to the Respiratory Therapy Department Director or Manager where you are performing your observation. Upon completion of the optional observation, return the completed form with your program application.

On the day of your Job Shadow, for Professional Dress, Hygiene concerns and Personal Safety, please ensure the following:

1. Business casual / Professional Appearance attire (Wearing Khaki pants or dress pants, collared "polo" style shirt or button down shirt, or hospital scrubs, no jeans). Not extreme clothing or words on clothing.
2. No open toed shoes, needs to be a comfortable, full leather shoe, socks above ankles.
3. Good personal hygiene, including no perfume or cologne or other unpleasant or unnatural odor on body or clothing, hair groomed, and no visible tattoos or body piercings (cover any visible tattoos).
4. Report to the Respiratory Care Department, arrive on time, plan to stay the agreed upon hours, and **<u>no cell phones in patient care areas.</u>**

Observer Information:

Name *(Please Print)* _____ Date: _____
First Middle Int. Last

Address: _____

City, State, ZIP: _____

Daytime telephone: _____ E-mail address: _____

Emergency Contact Name: _____Phone Number: (_____) _____

Date and time of requested observation _____

ATTENTION! <u>All HIPPA and Social Media restrictions will apply as a guest during your observation time.</u>
Disclosing patient identification, which includes patient photos, names, or anything that could potentially identify the patient, through conversation, which includes social media (Facebook, Twitter, etc.) is strictly forbidden and could face prosecution or fined if found guilty under HIPPA law if found guilty.

NOTE: Some hospitals have additional requirements, such as proof of TB test. You need to discuss any hospital specific requirements prior to your visit. <u>You MUST provide the clinical affiliate 24 hours' notice if you need to cancel or reschedule. Failure to do so may adversely affect your application to the program.</u>

Job Shadow/Volunteer's Name: _____

Date: _____ Start time: _____ End Time: _____ Total hrs: _____

Total hours spent job shadowing on this date: _____

Recommended procedures or tasks to observe: Aerosol or Nebulizer treatments, Oxygen set-ups, ABG, Bronchoscopy, Ventilator Management, suctioning, PFT, Intubation, Extubation, EKG, other ICU work.

Please document areas seen, observed procedures/tasks or comments:

_____

_____

_____

Respiratory Therapist Preceptor Signature: _____

Subsequent Job Shadowing day (If applicable)

Date: _____ Start time: _____ End Time: _____ Total hrs: _____

Total hours spent job shadowing on this date: _____

Recommended procedures or tasks to observe: Aerosol or Nebulizer treatments, Oxygen set-ups, ABG, Bronchoscopy, Ventilator Management, suctioning, PFT, Intubation, Extubation, EKG, other ICU work.

Please document areas seen, observed procedures/tasks or comments:

_____

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Respiratory Therapist Preceptor Signature: _____

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Director or Coordinator Signature: _____

Hospital Name: _____

Hospital Address: _____

City, State, Zip: _____

Daytime Telephone: _____ E-mail address: _____