

## Mentor Information Sheet Volunteer Services

Thank you for agreeing to act as a Mentor at the University of Maryland Capital Region Health for an observer/shadower. As a mentor you are providing an environment for the observer/shadower to gain a valuable educational experience in the health care setting. Part of this includes assuming responsibility for directing the observer/shadower in their interactions with patients and staff.

As you prepare to participate as a mentor please note the following;

1. Relatives of the Observer **may not** act as a mentor.
2. Shadowing is limited to 5 days within a 3-month period within the same department.
3. The minimum age to observe/shadow is 16 years old (no exceptions!). Participants under the age of 18 must provide written permission from a parent or legal guardian. This must include whether permission is given to shadow in the Operating Room/ Emergency Department or other areas where procedures are occurring.
4. Mentors must provide required paperwork at least one month ahead of time from the observational experience to the Volunteer Services Department.

Completed forms can be emailed, mailed or faxed to UM Capital Region Health Volunteer Services Department

**Email:** [UMCapitalregionvolunteer@umm.edu](mailto:UMCapitalregionvolunteer@umm.edu). Email Subject "Observational Shadowing Request Mentor Form – Applicant First Name & Last Name".

**Fax:** 240-677-3041

5. Observers/shadowers must provide required paperwork at least one month ahead of time from the observational experience to the Volunteer Services Department. Observers must also provide vaccination documentation to EOHS (Employee Occupational Health Services) before being authorized to begin observing/shadowing, including providing Influenza Vaccine (flu shot) during the flu season (typically October-March) and 1 recent (within 3 months) negative PPD (TB) skin test for tuberculosis screening.
6. Observers/shadowers cannot participate in patient care in any manner.
7. Observers/shadowers are **not** allowed to have any hands-on experiences.

### Mentor Responsibilities

1. Obtaining consent from the patient before the Observer/shadower can observe you with the patient (consent can be verbal or written)
2. Facilitating observer/shadower learning objectives
3. Ensuring observer/shadower does not enter Isolation Rooms (no exceptions!)
4. Ensuring that the observer/shadower adheres to the UM Capital Region Health Hand Hygiene policy
5. Ensuring the observer/shadower adheres to UM Capital Region Health standards of Service Excellence
6. Educating the observer/shadower on patient and business confidentiality, privacy, HIPAA, and infection prevention
7. Communicating to the observer/shadower in advance regarding appropriate dress code for the area in which they will be observing.



The shadowing/observation program is the only program available for non-hospital personnel to have a hospital educational experience. Other exposures of an outside visitor is **not acceptable** and could result in disciplinary action because of the high risk exposure to the visitor, patients, employees, and hospital. This means an employee, physician, or volunteer may not bring their friend and/or family member to work with them.

Questions? Contact the Volunteer Services Coordinator at 240-677-1057 or [UMCapitalregionvolunteer@umm.edu](mailto:UMCapitalregionvolunteer@umm.edu)



**Observational/Shadowing Experience Mentor Agreement**  
Volunteer Services

Observer/Shadower Name (please print): \_\_\_\_\_

Mentor Name (please print): \_\_\_\_\_

Mentor's Department: \_\_\_\_\_

Mentor's Phone Number: \_\_\_\_\_ Mentor's Email: \_\_\_\_\_

- I have been in communication with the above-named observer/shadower, who would like to have an observational/shadowing experience with me.
  - YES       NO
- I am accepting the above-named observer/shadower to have an observational/shadowing experience with me.
  - YES       NO
- I have communicated with my department that the above-named observer/shadower will be engaged in an observational/shadowing experience with me.
  - YES       NO

The dates and times the observer and I agreed upon for shadowing are as follows (*please note the Observation / Shadowing Program is limited to 5 days over a 3-month period **ONLY**, no exceptions*):

Date #1: \_\_\_\_\_ Start Time: \_\_\_\_\_ AM/PM      End Time: \_\_\_\_\_ AM/PM

Date #1: \_\_\_\_\_ Start Time: \_\_\_\_\_ AM/PM      End Time: \_\_\_\_\_ AM/PM

Date #1: \_\_\_\_\_ Start Time: \_\_\_\_\_ AM/PM      End Time: \_\_\_\_\_ AM/PM

Date #1: \_\_\_\_\_ Start Time: \_\_\_\_\_ AM/PM      End Time: \_\_\_\_\_ AM/PM

Date #1: \_\_\_\_\_ Start Time: \_\_\_\_\_ AM/PM      End Time: \_\_\_\_\_ AM/PM

- The observation experience will take place in the following location(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- I agree to act as the mentor to the observer/shadower during their educational experience at Capital Region Health. As such, I assume responsibility for directing this individual in their interactions with patients and staff.
- Additionally, I will be responsible for:
  1. Introducing the observer/shadower, explaining why they are present, and requesting the consent of any patient whose care is being observed. If an attending physician is



participating in the patient care, I will also request the physician's permission to observe. I will immediately honor any refusals by immediately moving the Observer to another location without comment.

2. Facilitating the observer/shadower learning objectives
3. Making sure the observer/shadower does **not** enter Isolation Rooms (*no exceptions*)
4. Encouraging the observer/shadower adherence to UM Capital Region Health standards of conduct and culture of safety
5. Explaining the importance and rules about patient and business confidentiality, infection prevention, privacy, and HIPAA
6. Ensuring the observer/shadower adherence to UM Capital Region Health's dress code policy
7. Ensuring the observer/shadower wears the appropriate identification badge while on hospital grounds
8. Supervising the observer/shadower at all times
9. Understanding that these educational experiences are for observation only and at no time will I permit an observer/shadower to participate in any patient care or ask the observer/shadower to perform any task that could put the Observer or hospital in jeopardy.
10. Terminating the educational experience if the observer/shadower fails to adhere to my instructions or if the continuance of the experience would result in a disruption of services to the hospital and/or its patients.

Mentor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Department Manager/Supervisor of Mentor**

*(signature of the respective department manager/mentor supervisor is required for all non-physician team members).*

The request for this mentor to participate in this observational/shadowing experience has been reviewed and approved.

\_\_\_\_\_  
Department Manager/Supervisor Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature