



# Clinical Shadowing Agreement

Please read this agreement carefully, complete every field, and sign at the end. Email this completed form and the HIPAA form to [info@endocrine.plus](mailto:info@endocrine.plus) before your first day of shadowing. You can type directly into this PDF.

## 1. Purpose and Our Right to End Shadowing

Endocrine & Diabetes Plus Clinic of Houston (the “Practice”) permits you to observe clinical care for educational purposes only. Shadowing is a privilege, not a right, and it is observation only.

**The Practice may stop your shadowing at any time, with or without notice, and for any reason.** This includes, but is not limited to, failing to follow this agreement, unprofessional or unsafe behavior, breaching patient privacy, missing scheduled days without notice, or a patient or staff member raising a concern. The Practice’s decision is final.

## 2. Eligibility

To shadow at the Practice, you must:

- Be at least **16 years old** on your first day of shadowing.
- Be currently enrolled in, or a recent graduate of, a high school, college, or health-professions program, or be actively preparing to apply to one.
- If you are under 18, have a parent or legal guardian sign this agreement (Section 9).

The Practice may ask for proof of age or enrollment and may decline any request to shadow.

## 3. Your Responsibilities

While shadowing at the Practice, you agree to:

- Stay with your assigned provider unless a staff member directs you otherwise.
- Follow all instructions from providers and staff, including infection-control and safety rules.
- Keep questions and discussion for appropriate moments, away from patients, as directed by your provider.
- Turn off your phone or set it to silent, and keep it put away in patient areas.

## 4. Our Expectations of You

- **Professionalism.** Be respectful, punctual, and courteous to patients, providers, and staff at all times.
- **Dress.** Wear clean, professional attire and closed-toe shoes. Scrubs are not required unless the Practice asks for them.
- **Health.** Do not come in if you are sick, have a fever, or have been exposed to a contagious illness.
- **Engagement.** Come prepared, stay attentive, and take an active interest in learning.
- **Boundaries.** Do not give medical advice, and do not discuss your own or anyone’s personal health matters with patients.

- **Honesty.** Tell us right away if you make a mistake, see a safety concern, or are unsure what to do.

Shadowing is unpaid. It does not create an employment relationship, and you will not receive compensation, benefits, or academic credit from the Practice unless separately agreed in writing.

## 5. Attendance and Schedule

**If you cannot come on a scheduled day, you must let us know at least 24 hours in advance.** Repeated no-shows, late cancellations, or last-minute changes may result in your shadowing being ended.

The clinic is open Monday to Friday, 8:00 AM to 4:30 PM Central. Tell us which days you can come in and for how long. Select Yes or No for each day and fill in your hours.

| Day                    | Available                                          | From (time)          | To (time)            |
|------------------------|----------------------------------------------------|----------------------|----------------------|
| Monday (Sugar Land)    | <input type="radio"/> Yes <input type="radio"/> No | <input type="text"/> | <input type="text"/> |
| Tuesday (Memorial)     | <input type="radio"/> Yes <input type="radio"/> No | <input type="text"/> | <input type="text"/> |
| Wednesday (Sugar Land) | <input type="radio"/> Yes <input type="radio"/> No | <input type="text"/> | <input type="text"/> |
| Thursday (Sugar Land)  | <input type="radio"/> Yes <input type="radio"/> No | <input type="text"/> | <input type="text"/> |
| Friday (Memorial)      | <input type="radio"/> Yes <input type="radio"/> No | <input type="text"/> | <input type="text"/> |

REQUESTED START DATE

REQUESTED END DATE

TOTAL HOURS YOU PLAN TO COMPLETE

## 6. Patient Privacy and Confidentiality

You will see and hear protected health information. Federal law (HIPAA) and Texas law require that it stay private. By signing, you agree that you will:

- **DO NOT** share, discuss, post, or write down anything that could identify a patient, in the clinic or outside it, including on social media, in messages, or with friends and family.
- **ONLY** discuss what you observe with your provider, and only in private.
- **DO NOT** look at, copy, or remove any patient records, schedules, or documents.
- **IMMEDIATELY** report any accidental disclosure of patient information to a provider or manager.

These duties continue after your shadowing ends. A breach of patient privacy will end your shadowing immediately and may lead to legal consequences.

## 7. Assumption of Risk and Release of Liability

---

I understand that being in a medical office involves some risks, including exposure to communicable illnesses, sharps, bodily fluids, and ordinary accidents such as slips or falls. I choose to shadow voluntarily and accept these risks.

- **Release.** To the fullest extent allowed by law, I release Endocrine & Diabetes Plus Clinic of Houston and its owners, providers, employees, and agents from any claims for injury, illness, or loss arising from my shadowing, except those caused by their gross negligence or willful misconduct.
- **Insurance.** I am responsible for my own health insurance and medical costs. The Practice does not provide workers' compensation, health, or accident coverage for shadowing participants.
- **Emergency care.** If I become ill or injured, I authorize the Practice to call emergency services and to contact my emergency contact listed below.
- **Personal property.** The Practice is not responsible for lost or damaged personal belongings.

If I am under 18, my parent or legal guardian agrees to this release on my behalf by signing Section 9.

## 8. Participant Information and Emergency Contact

---

### Shadowing participant

PRINTED NAME

DATE OF BIRTH

PHONE

EMAIL

SCHOOL OR PROGRAM (IF ANY)

TRACK (PRE-MD, PRE-PA, PRE-NP, ETC.)

### Emergency contact

NAME

RELATIONSHIP

PHONE



## 9. Acknowledgment and Signatures

---

By signing below, I confirm that I have read and understood this agreement, including the release of liability, that I will follow it, and that I understand the Practice may end my shadowing at any time.

☐ I confirm that I meet the eligibility requirements in Section 2, including being at least 16 years old.

### Shadowing participant

SIGNATURE (TYPE FULL NAME OR SIGN BY HAND)

DATE

### Parent or legal guardian (required if the participant is under 18)

PRINTED NAME

PHONE

SIGNATURE

DATE

### Endocrine Plus representative (office use)

PRINTED NAME AND TITLE

SIGNATURE

DATE

## 10. Essay

---

In 350 words or less, please tell us why you want to be a healthcare provider.