MEDICAL PATHWAYS PROGRAM

INFORMATION
JANUARY - APRIL 2025

GUNNISON VALLEY HEALTH

WWW.GUNNISONVALLEYHEALTH.ORG

MEDICAL PATHWAYS PROGRAM

Thank you for choosing to participate in Gunnison Valley Health's Medical Pathways Program. This program is designed to provide you with an opportunity to explore different career paths in the field of healthcare through hands-on experiences led by working professionals. We highlight a wide range of specialties, including emergency medical technicians, behavioral health providers, supply chain officers, physical therapists, human resources professionals, radiologists, medical coders, lab technicians, labor and delivery nurses, orthopedic surgeons and more.

PROGRAM INFORMATION

- The program will start January 8 and end April 2, 2025.
- All program activities will take place at Gunnison Valley Hospital, students will enter in the south entrance of the hospital and meet in the conference room. The exception is February 5, when students meet at the Senior Care Center and students will come to the main entrance of the Senior Care Center. There is no cost to participate in the program; we only ask for your commitment to the entire program.
- Your commitment is Wednesday evenings from 5:30 - 7:30 p.m.
    - 5:30 - 6:oo p.m. - Dinner and introductions
    - 6:00 - 6:45 p.m. - Rotation 1
    - 6:45 - 7:30 p.m. - Rotation 2
- Pathfinders will receive a t-shirt and badge, which they are encouraged to bring to each session.

SCHEDULE

January 8
January 15
January 22
January 29
February 5
February 12
February 26
March 5
March 12
March 26
April 2 Graduation dinner

Please note: Schedules may change slightly from time to time due to Gunnison Valley Health's employee availability. You will be notified in advance if a schedule change will occur.

When registering for the program, you are required to watch the Health Insurance Portability and Accountability Act (HIPAA) video in advance. Use this QR code or enter this link for access. www.gunnisonvalleyhealth.org/medicalpathway

Parents and students are invited to the Gunnison Valley Health conference room on December 18, 5:30 - 6:30 p.m., for a brief presentation and Q&A session to learn more about the program. This is an excellent opportunity to get registered and make sure this program is a good fit for you. Registration is limited, and we want to ensure that you understand the program and the time commitment required.

MEDICAL PATHWAYS PROGRAM REGISTRATION FORM

STUDENT NAME: _____ **DOB:** _____

ADDRESS: _____ **PHONE:** _____

EMAIL: _____ **SCHOOL LOCATION:** _____

GRADE: _____ **INTERESTED HEALTHCARE FIELD:** _____

UNISEX SIZE FOR T-SHIRTS (please circle) **:** **XS** **S** **M** **L** **XL**

BEST CONTACT FOR WEEKLY REMINDERS AND UPDATES: _____

TERMS AND CONDITIONS AGREEMENT

As a member of Gunnison Valley Health's Medical Pathways Program, I agree to the following:

1. I will treat all information given to me with the expectation that the information will not be disclosed and will be treated as confidential. This includes but is not limited to:
   - services provided to patients and their families
   - information received from Gunnison Valley Health staff
2. I will not access or take photos of patients and/or organizational information.
3. I will not take patient information from the premises of Gunnison Valley Health in paper or electronic form.
4. I agree to maintain the confidentiality of any information I learn or people I see while associated with Gunnison Valley Health.
5. I understand that participation in these activities is entirely voluntary and requires participants to follow instructions and abide by all applicable rules and the standards of conduct.
6. I understand that in the case of an emergency, every effort will be made to contact the parent or guardian. In the event the parent or guardian cannot be reached, permission is hereby given to Gunnison Valley Health to undertake treatment as required.

Student, please check:

☐ I accept the terms and conditions and understand that any violation of this agreement could result in being removed from the Medical Pathway Program.

☐ I have watched and understood the Health Insurance Portability and Accountability Act (HIPAA) video located at www.gunnisonvalleyhealth.org/medicalpathway

☐ I am committed to participating in the entire Medical Pathway Program from January to April. If I cannot attend a session, I will advise a Gunnison Valley Health staff member in advance.

Student Signature: _____ **Date:** _____

As the parent/guardian, I consent to point 6 and acknowledge my child understands the terms and conditions agreement.

Parent/Guardian Name: _____ **Date:** _____

Parent/Guardian Signature: _____ **Emergency Contact Phone:** _____

PHOTO RELEASE FORM

I hereby grant Gunnison Valley Health System permission to use my likeness and testimony in writing, a photograph, video, or other digital media (in any and all of its publications, including web-based publications, without payment or other consideration.

I understand and agree that all materials will become the property of Gunnison Valley Health System and will not be returned.

I hereby irrevocably authorize Gunnison Valley Health System to edit, alter, copy, exhibit, publish, or distribute this material for any lawful purpose. In addition, I waive any right to inspect or approve the finished product wherein my likeness and testimony appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of said materials.

I hereby hold harmless, release, and forever discharge Gunnison Valley Health System from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

I HAVE READ AND UNDERSTAND THE ABOVE RELEASE. I AFFIRM THAT I AM AT LEAST 18 YEARS OF AGE, OR, IF I AM UNDER 18 YEARS OF AGE, I HAVE OBTAINED THE REQUIRED CONSENT OF MY PARENTS/GUARDIANS AS EVIDENCED BY THEIR SIGNATURES BELOW. I ACCEPT:

Print Name: _____

Signature: _____ | Date: ____ / ____ / _____

If under 18, signature of parent/guardian.

Parent Signature: _____ | Date: ____ / ____ / _____

GUNNISON VALLEY HEALTH

HOSPITAL
SENIOR CARE CENTER
HOME MEDICAL SERVICES
ASSISTED LIVING
FAMILY MEDICINE CLINIC
MOUNTAIN CLINIC
CAMPUS HEALTH CENTER
FOUNDATION