PANTHER
Pediatric Dentistry

Panthers Observing the Pride Shadowing (POPS) Program

Personal Information – POPS is reserved for pre-dental and dental students, resident doctors, and dentists

_____ _____
Name Date of Birth

_____
Address City, State Zip Code

_____ _____
Cell Phone Email Address

_____
Emergency Contact Relationship Phone #1 Phone #2

Project Information

Kari A. Cunningham, DMD, LLC dba: Panther Pediatric Dentistry
26250 Euclid Ave. Suite 203 Euclid, OH 44132 Phone: 216-938-8501 Fax: 216-938-8502
email: office@pantherpediatricdentistry.com Website: www.pantherpediatricdentistry.com
HINT: You should review our website and familiarize yourself with what this practice stands for. Come with questions and be ready to soak up a lot of good information and skills that will be helpful in your journey.

***NOTE:** This shadowing opportunity is available for up to 4 days the dental office is in operation with Dr. Cunningham present and treating patients. Patient care takes place on Mondays and Wednesdays from 8:30a – 3:00p and Tuesdays are surgery days from 6:30a – 2:00p. Only one POPS student will be scheduled per day.

Please list desired dates to shadow:_____
_____

*Upon review and acceptance of your POP application, dates will be finalized with the POP shadowing program administrator.

*Please note that temperatures will be taken upon entry to the practice. Masks are required to enter the office and the POP student should bring their own eye protection. Face shields will be provided.

*Scrubs or business casual attire with a lab coat is acceptable attire for this clinical shadowing experience.

Please describe why you are interested in and what you want to get out of the Panther Pediatric Dentistry POPS Program.

It is important to understand that the office at PPD can be fairly fast-paced and that Dr. Cunningham wants you to be able to have time to converse throughout the day and while children are being treated. Please know that the behavior of children can be quite unpredictable and may impact the ability to finish a conversation or explain a procedure because great attention must be placed on the safe completion of treatment. To maximize your shadowing experience, you should have an idea of the things you would like to see and inquire during your time at the office. If there are questions left unanswered, please know that you can continue the conversation with Dr. Cunningham via email at office@pantherpediatricdentistry.com.

To participate in the POPS Program, you **must provide** proof of Hepatitis B vaccination, BLS for healthcare providers certification, and the completed Observation Expectations quiz along with this application. Once you have submitted a complete application, please allow up to 2 weeks before a decision is made and shadow dates are scheduled.

Please understand that participation in the POPS Program does not guarantee employment at Kari A. Cunningham, DMD, LLC dba: Panther Pediatric Dentistry should a vacancy be advertised, nor is it a requirement to be employed by the company.

I certify that the statements made in this POPS Program application are true and correct and have been given voluntarily. I understand that this information may be disclosed to any party with legal and proper interest, and I release Kari A. Cunningham, DMD, LLC dba: Panther Pediatric Dentistry from any liability whatsoever for supplying such information.

_____ _____

Signature Date

For Office Use

Received by:_____ Date: _____

Consent for participation in the POP Shadowing Program at Kari A. Cunningham, DMD, LLC and Confidentiality Agreement

I understand that I have applied to participate in the Panthers Observing the Pride Shadowing Program ("POPS") at Kari A. Cunningham, DMD, LLC dba: Panther Pediatric Dentistry ("PPD"). I understand that, in participating in POPS, I will be exposed to the normal risks of any dental office visitor, as well as possible additional risks that arise because I will be in patient care areas and observing patient care.

I understand and agree that I waive, for myself, any and all claims, including any negligence claims which I might have against PPD, or its agents or representatives, in any way arising from or relating to POPS, except for claims arising out of the gross neglect of reckless or willful misconduct of PPD or its agents, or representatives. I hereby agree and that I will not sue PPD on behalf of myself, nor will I and release PPD from any claims I may have against it except for gross negligence or willful or reckless misconduct on the part of PPD, its officers, agents, and employees.

In the event of exposure to blood or other bodily fluids from a patient who is a carrier of a contagious or infectious disease or a patient who is, and the judgment of PPD, at risk of carrying a contagious or infectious disease, PPD shall, with my consent, administer immediate precautionary treatment to me that is consistent with current medical practice without any further consent from me. I shall pay for the initial screening test or prophylactic medical treatment should the need arise. PPD shall have no responsibility for other any further diagnosis, medication or treatment and I acknowledge and assume the risk of me observing or being in the immediate presence of patients at risk of carrying a contagious or infectious disease.

I certify that I have no known physical and mental illness or condition, including any contagious disease, which could be detrimental to the welfare or interfere with the care of any of PPD's patients or staff. I certify that I am currently covered by health insurance or Medicaid and that it shall remain in effect in the end of my participation in POPS.

I understand that the PPD will not provide transportation or meals for me while I participate in the program in that these expenses must be borne by me.

I understand that the PPD does not view this observation experience as an educational record and I will be giving no confidentiality considerations under the Family Education Rights and Privacy Act ("FERPA").

I will wear appropriate attire for POPS. Participants may not wear open-toe shoes, sleeveless shirts, sweatshirts/pants, jeans, exposed midriffs, heavy perfume or cologne, dangling jewelry, or jewelry in tongue or face piercings. Visible tattoos must be covered. Scrubs or business casual attire is advised. No sweatshirts or hoodies permitted. I will not be permitted to remain at PPD unless I am dressed appropriately.

Consent for Participation in POPS Program and Confidentiality Agreement continued

I understand the following:

Confidential means that something is to be kept private or secret; that it is not to be repeated to anyone or given to anyone.

Confidential Information means any and all information that I may learn about a patient at PPD. This information is automatically private or secret. Confidential information about a patient includes: name, address, diagnosis, medical information, the medical notes, resumes, pictures, and medical records including X-rays and medicines, as well as any descriptive that could cause any person to become aware of the identity of a patient. Confidential information also includes the name of any person at PPD who is not a PPD employee or volunteer, because all patients are not easily identified by where they are in PPD or how they are dressed.

Disclosure means sharing or telling someone something I know about someone that is private or confidential.

Nondisclosure means not sharing or telling someone something. It means not to write, speak, or gossip about any patient I see or talk to at PPD.

I understand that while I am at PPD, I may obtain confidential information about the practice's patients. I understand for myself that POPS participants are to maintain in strict confidence all information and data related to PPD's patients, and shall not disclose such information to any third party, including any family member or friend, under any circumstances. Additionally, confidential information is not to be removed from PPD or discussed with other participants in the same program. I understand for myself that patient confidentiality is of such great importance that it is never to be disclosed to anyone outside of PPD no matter how long after participating in the program.

By signing this form, I agree that I have read, understand, and agree to the terms in both pages of this consent form and confidentiality agreement and agree to its terms. I give my full consent to participate in the Panthers Observing the Pride Shadowing Program at Kari A. Cunningham, DMD, LLC dba: Panther Pediatric Dentistry.

Observer:

_____

Print Name | Signature of Observer | Date

_____

Home Address | City, State | Zip Code

_____

Name of School

Observation Expectations – POPS Program

CONFIDENTIALITY

As an observer, you are governed by the same code of ethics that applies to Panther Pediatric Dentistry employees. Patients expect PPD to keep their charts, medical information, and even the fact that they are patients of record confidential. This understanding between the patient and dental office is an implied contractual agreement and is legally enforceable through HIPAA (Health Information Portability and Accountability Act of 1996).

All observers are required to sign the statement about patient confidentiality that becomes part of your permanent record of the POPS Program. Remember:

- Leave all patient information where it belongs: in the dental office.
- You will be provided information concerning patients on a "need-to-know" basis only.
- Do not leave written information unguarded. Destroy such materials before leaving the area.
- To say anything about a patient is to say too much.

INFECTION CONTROL

Hand washing is the single most effective method of preventing transmission of infections. Hand-washing is a 15 to 30 second process. Use a paper towel to turn off the faucet after drying hands.

FIRE SAFETY

Use the word **SEE** for locating fire alarms and extinguishers, stairwells, exits,
The term **CODE RED** means fire. For fire a medical emergency, call 911
The letters **RACE** tell you how to proceed in a fire emergency:

Rescue anyone in need and clear corridors.
Activate the fire alarm by pulling the alarm pull station and call 911.
Confine smoke and fire by closing all doors.
Exit the area or extinguish the fire only if you can do it without danger yourself. Fire extinguishers within the practice are located near the door in the staff break room and at the front desk.

POPS Program Observation Quiz

1. What procedure would you follow if you see smoke or fire?
    A. Race, ask, contact, evaluate
    B. Pull, activate, send, signal
    C. Rescue, activate, confine, exits/extinguish
    D. Pull, aim, squeeze, sweep

2. What number would you call in the event of a medical emergency or fire?
    1. 411
    2. 211
    3. 911
    4. 711

3. At PPD, you would find a fire extinguisher near a(n):
    A. Door entrance
    B. Front desk
    C. Bathroom
    D. A and B only

4. T F The single most important thing to do to reduce the risk of infection is hand-washing.

5. You learn one of your neighbors has a child who is a patient of PPD. What can you tell your mutual friends about the child's dental condition?_____

6. T F Patient information is confidential and should not be shared. What you see here and hear here stays here when you leave here.

I certify that I have read and completed the observation quiz on my own and have answered to the best of my ability. By signing below, I understand what is expected of me as an observer in the PPD office. NOTE: please bring this completed quiz and signed form with you on the first day of your POPS Program experience.

_____ _____

Signature Date

For Office Use

Received by:_____ Date: _____

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