TheraPlay Spot
PEDIATRIC OCCUPATIONAL & PHYSICAL THERAPY
☎316.618.1252 f:316.869.2277 www.theraplayspot.com 560 N Exposition, Wichita, KS 67203

Shadowing-Volunteering Exchange Policy

TheraPlay Spot is in the business of providing high quality occupational and physical therapy to children with additional needs. Many OT and PT students, or even students considering OT or PT as a potential field of study, request to shadow our therapists during treatment sessions. This takes up significant additional time on the therapist's part, because they are answering the students' questions and helping the students pursue their passion with their upcoming therapy careers.

As a way to create a win-win exchange of time, TheraPlay Spot requests that the student who shadows also volunteers at a 1:1 rate. That is, for each hour spent shadowing a therapist, an hour is also spent volunteering either for the supervising therapist or elsewhere in the clinic. We are happy to give full credit for all hours spent at the clinic as required by a student's school, since all of the hours will be relevant to a therapy practice.

Volunteer duties could include anything from helping therapists with setup of equipment, helping therapists prepare for a treatment activity, wipe-down of mats and/or equipment, cleanup of messes created during therapy sessions, de-cluttering of treatment areas, or possibly other miscellaneous tasks that are in alignment with the student's personal skillset. For example, for the student who has excellent computer skills, we can come up with a job for that. For the student who is skilled with organizing, we have a job for that. If the student is artistic, we have a job for that, too.

TheraPlay Spot appreciates this mutually beneficial relationship.

Kris Dickinson, MS, OTR/L
TheraPlay Spot Owner/Director

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Shadowing-Volunteering Exchange Agreement

I, (print name)_____, *request to shadow and volunteer at TheraPlay Spot at a 1:1 exchange rate*. In exchange for each hour of shadowing with a licensed therapist, I willingly volunteer an hour of my time either for the supervising therapist or in another manner that benefits the clinic.

Initial each section if in agreement:

_____ I agree to honor the Privacy Practices Act (HIPAA guidelines) and will keep all client information confidential. Additionally, no client paperwork will leave the clinic.

_____ I understand that I may be invited by the therapist to interact with a client during therapy sessions, but otherwise I will refrain from attempting to neither lead therapy sessions in any way, nor will I physically touch clients in any manner without direction from a licensed therapist.

_____ To the best of my knowledge, I certify that I am in good health and have no preexisting conditions that may have an effect on a patient's health or recovery i.e., tuberculosis, influenza etc. I also understand that I will not be covered by health insurance, workman's compensation insurance or life insurance provided by TheraPlay Spot.

_____ I am open to volunteering in whatever way is most beneficial to my supervising therapist or at the clinic in general.

_____ I will act in a professional manner and I must abide by the rules, regulation, policies and procedures of the TheraPlay Spot facility where assigned for my experience. In addition, I will wear the appropriate attire.

_____ I understand that my continued participation in the Shadowing/Volunteering Program is at the sole discretion of TheraPlay Spot.

In addition to being helpful with the therapist or clinic needs of the moment, my interests and strengths include: ☐ n/a ☐ _____
_____

I need to disclose the following, which will impact how I can participate: (use back of this sheet if needed ☐ n/a ☐ _____
_____

_____ _____
Signature Date

Shadowing-Volunteering Exchange Application

Name_____ Today's Date_____

Phone _____ Email _____

Home Address _____

Street Address *City/State* *Zip Code*

Person to Notify in-case of Emergency:

_____ _____ _____

Full Name *Relationship* *Phone*

I want to shadow: ☐ OT ☐ PT

Why do you want to Shadow/Volunteer at TheraPlay Spot?

(Please give a brief description) _____

_____

_____

Shadowing/Volunteer expectations ***(What do you expect to learn)***:

_____

_____

_____

I will need written documentation for my school as proof of my hours. ☐ Yes ☐ No

My preferred total number of hours in the clinic: _____ Deadline: _____

Preferred day(s) and time(s):

☐ Monday	☐ Mornings	☐ Afternoons # of hours: _____
☐ Tuesday	☐ Mornings	☐ Afternoons # of hours: _____
☐ Wednesday	☐ Mornings	☐ Afternoons # of hours: _____
☐ Thursday	☐ Mornings	☐ Afternoons # of hours: _____
☐ Friday	☐ Mornings	☐ Afternoons # of hours: _____
☐ Saturday	☐ Mornings	☐ Afternoons # of hours: _____

Do you have any past criminal convictions or current criminal charges pending against you?
Please Explain

_____

_____

Other Comments: _____

_____

_____ _____

Signature Date

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Release & Hold Harmless Agreement

I, (print name)_____, understand that my participation and/or involvement in a therapy clinic carry with it the potential for certain risks, some of which may not be reasonably foreseeable.

I further acknowledge that these risks could cause me, or others around me, harm, including, but not limited to, bodily injury, damage to property, or emotional distress.

I am a willing participant in shadowing licensed therapists and volunteering at TheraPlay Spot.

By signing this agreement, I agree to release, indemnify, and hold harmless **TheraPlay Spot,** as well as all employees, independent contractors, representatives, etc. from all losses, claims, theft, demands, liabilities, causes of action, or expenses, known or unknown, arising out of my participation with shadowing and volunteering.

_____ _____

Signature Date

_____ _____

Witness Signature Witness Printed Name