PeaceHealth
Center for Medical Education and Research

Application for Observation Experience at PeaceHealth

Please Print Legibly

Applicant Information

Last Name: _____ First name: _____ M. I. ___

Street Address _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell Phone #: _____

Email: _____ Date of Birth: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone #: _____

Caregiver/Dept you will be observing: _____

Preferred date of Observation _____

Reason for observation request: _____

Please verify the following requirements have been met. You will be required to provide copies of immunizations with your documentation.

Date	Requirement
	Tuberculosis (TB) Testing • Documentation of an IGRA blood test (TB QuantiFERON or T-SPOT) within the past 12 months or for non-employees a 2 step Tuberculin Skin Test in the prior 12 months (2 separate PPD TB skin tests 1-3 weeks apart). Provide the millimeter measurement recorded for any positive read. Provide treatment records (including a chest x-ray) if you have previously tested positive.
	Measles, Mumps, Rubella (MMR) • Two MMR vaccinations, OR • Positive MMR titers
	Chicken Pox (Varicella) • Two Varicella vaccinations, OR • Positive Varicella titer
	Hepatitis B • Documented series of Hep B vaccinations AND • Positive Hep B surface antibody titer following the completed vaccine series
	Tetanus/Diphtheria/Pertussis (Tdap) • Tdap as a booster every 10 years
	Influenza (required October through March) • Vaccination for the current season

Read and initial each statement below regarding observation expectations:

- — I understand that I will not be permitted to engage in any patient care activities.
- — I will not be asked or allowed to answer specific questions about a patient's care or treatment, or otherwise provide medical or professional opinions.
- — I will be expected to follow all of PeaceHealth's polices, rules and regulations, specifically those regarding infection control, safety and confidentiality as directed by my sponsor. If I breach any policies or obligations set forth by my sponsor, my experience may be terminated immediately.
- — I understand that I must remain with my sponsor at all times and follow all of his/her directions.
- — I understand that I am on PeaceHealth property at my own risk.
- — In the event patient care and/or PeaceHealth needs necessitate dismissal of observation experiences, I may be asked to leave immediately or reschedule my experience with minimal notification.
- — I understand if I have any of the following illnesses, I must reschedule my observation for a later date:
    - o Flu, viral, respiratory infection with or without cough, shortness of breath
    - o Nasal congestion, runny nose and/or sore throat
    - o Nausea, vomiting, diarrhea
    - o Skin rash, wounds, open sores
    - o Fever 100 F or higher, with or without chills
    - o ANY infectious or communicable illess
- — I have reviewed the orientation information provided with the application.

I **confirm** that the information provided on this application is true and complete to the best of my knowledge.

Applicant/Observer Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date _____
(Required if under age 18)

SPONSOR ATTESTATION

I confirm that the observation requested above has been approved by the department/unit manager where the experience will occur. As sponsor, I will ensure that:

- Verbal consent has been obtained from the patient, before the observer enters the patient's room and the patient is allowed an opportunity to decline to have the observer present during care.
- The purpose of the observer's presence has been thoroughly explained and all questions the patient may have, have been answered to the patient's satisfaction.
- If the patient consents to the observation, then the Sponsor will:
    - Introduce the observer to the patient and other caregivers;
    - Indicate clearly this individual's reason for observation;
    - Ensure the observer will not participate in hands on patient care in any way; and
    - Document patient verbal consent in the patient's medical record when applicable.

N95 fit testing is optional for the observer and subject to the decision of the Sponsor based on work hazards.

- Sponsor will notify Center for Medical Education and Research if N95 fit testing is required prior to observation.
- In high community transmission situations, a N95 mask is recommended but not required:
    - During aerosol generating procedures (AGP)
    - Within 6 feet of the surgical field during an AGP (intubation, extubation, CPR)
    - Working in high risk departments such as ED, Urgent Care, Labor and Delivery
- The observer can be fit tested prior to observation at the discretion of the observer or Sponsor.

Observers in areas where patient procedures are performed including but not limited to Operating Rooms, Interventional Radiology, Endoscopy, and Childbirth Centers are subject to the following additional requirements:

- Managers of the area where the procedure/care will take place will approve the request;
- Requests from Clinicians will have the name of the observer and the reason for the observation submitted to the procedural area leadership when the case is scheduled;
- The observer's presence and purpose is pre-scheduled;
- Written consent is required and will be obtained on "The Surgical Procedural and Consent form";
- There will be no observations of emergency procedures;
- All observers to the surgical department will have appropriate surgical attire in restricted areas;
- Documentation will be recorded in the patient's progress notes with date and time of consent given and the name of the observer.

PeaceHealth Sponsor Signature: _____ Date: _____

Manager who approved the experience: _____ Unit: _____