PeaceHealth
Center for Medical Education and Research

Application for Clinical Observation at PeaceHealth

Please Print Legibly

Applicant Information 2026-2027

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

Street Address _____ Apt: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell Phone #: _____

Email: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone #: _____

Caregiver/Dept you will be observing: _____

Preferred date(s) of Observation _____

Reason for observation request: _____

Requirements verification

The following requirements are to be met with proof of documentation through medical records:

Date	Requirements
	Two-step TB test **or** IGRA blood Test within the last calendar year with negative result or positive result with f/u treatment
	Measles, Mumps, Rubella (MMR) immunization
	Diphtheria, Pertussis, Tetanus (DPT) immunization
	Varicella (Chicken Pox) immunization
	Hepatitis B immunization with positive titer
	Seasonal Flu vaccination (Oct-Mar) **and** where vaccination received _____
	Reviewed orientation manual provided with the application and agreed to policies

Attestation

Please read and initial each statement below regarding observation expectations:

_____I am at least 16 years of age.

_____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 PeaceHealth's policies, rules and regulations, specifically those regarding infection control, safety and confidentiality as directed by my sponsor/designee. If I breach any policies, my permission to act as an observer will be withdrawn and I may be asked to leave immediately.

_____I understand that I must always remain with my sponsor/designee and follow his/her directions.

_____I understand that I am on PeaceHealth property as an observer at my own risk and insurance coverage. I will not be indemnified/insured by PeaceHealth.

_____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:

- Flu, viral, respiratory infection with or without cough, shortness of breath
- Nasal congestion, runny nose and/or sore throat
- Nausea, vomiting, diarrhea
- Skin rash, wounds, open sores
- Fever 100 F or higher, with or without chills
- ANY infectious or communicable illness

_____I understand that if I cannot provide Seasonal Flu vaccination information, I will be required to wear a source control KN95 face mask (provided by PeaceHealth) while on site.

_____I have reviewed the orientation information provided to me and will comply as set forth.

_____I understand that I am responsible for submitting all required documents upon request by PeaceHealth.

Confidentiality Agreement

PeaceHealth follows the highest standards of care and diligence in protecting the Confidential Information (defined below) entrusted to, or created by, PeaceHealth. Therefore, PeaceHealth will not employ, work with, do business with, contract with, grant access to, or entrust Confidential Information to anyone (either directly or indirectly through an intermediate person or organization) who does not also agree to abide by those same high standards of care and attention.

I understand that I will not be permitted to work for or on behalf of PeaceHealth, or be granted access to PeaceHealth data, unless and until I agree (and by my signature below I do agree) to abide by all the terms of this Confidentiality Agreement (the "Agreement"). "Confidential Information" means all tangible written and verbal information that is created by, retained by, or entrusted to PeaceHealth to carry out PeaceHealth's mission, and includes:

- all Protected Health Information (PHI), as that term is defined by the Health Insurance Portability and Accountability Act (HIPAA), in whole or in part;
- all material non-public information (MNPI) concerning PeaceHealth's caregivers and providers;
- business models, planned business transactions or arrangements, customer and supplier lists, marketing plans, financial and technical information, trade secrets, know-how, ideas, designs, drawings, specifications techniques, operational designs and approaches, programs, systems, processes, and computer software; and
- all information or material (tangible and intangible) that has or could have commercial value or other utility purposes to PeaceHealth.

I understand and agree that:

1. I will diligently preserve, protect, and maintain the confidentiality, privacy, and security of Confidential Information, and I will abide by all PeaceHealth's (or if I'm employed by another entity under an arrangement with PeaceHealth, then my employer's) policies, procedures, and practices related to the protection of Confidential Information and/or PHI under HIPAA.
2. Confidential Information is the exclusive property of PeaceHealth, and I will not acquire, access, use, or disclose Confidential Information except for the purpose of carrying out my authorized duties under my employment (or if I'm employed by another entity under an arrangement with PeaceHealth, then my employer's) arrangement with PeaceHealth.
3. I may NOT access/view or modify PHI related to myself, family members, or friends, including for work-related purposes unless another person qualified to perform the required task is unavailable and I have obtained prior written or verbal approval from my leadership.
4. Authorization, consent, or permission from the patient/surrogate, written or otherwise, does not permit me to access electronic PHI for non-work reasons except through means established for that purpose, such as "My PeaceHealth."
5. I will be diligent, attentive, and careful in safeguarding all Confidential Information in accordance with PeaceHealth's (or if I'm employed by another entity under an arrangement with PeaceHealth, then my employer's) information security policies, procedures, and practices, and I additionally agree to abide by all the following:
    - I will not leave Confidential Information in an unsecured place or environment.

- I will properly secure my workstation when leaving the direct physical vicinity.
- I will not disclose my username and password (login) combination to another person for any reason, and I will not use another person's username and password (login) combination.
- I will not use my PeaceHealth password as the same password that I use for any non-PeaceHealth accounts.
- I will not use my personal device (e.g., computer, cell phone, iPad, tablet, etc.) to record, store, share, or exchange PHI unless specifically permitted by PeaceHealth's (or if I'm employed by another entity under an arrangement with PeaceHealth, then my employer's) policies and procedures.
- I will not send or receive Confidential Information using my personal email or social media accounts.
- I will not discuss Confidential Information in a public place or with persons not authorized to receive such information.
- I will only access Confidential Information needed to perform my work-related responsibilities.
- I will immediately report all suspicious activity, behavior, and suspected information security or privacy incidents.

6. I understand that my obligations under this Agreement continue beyond the end of my service to PeaceHealth, and when my relationship with PeaceHealth ends, I will not retain or transfer any Confidential Information unless authorized in writing by PeaceHealth's System Vice President for Organizational Integrity.
7. I further understand that if I breach my obligations under this Agreement, my employment, service arrangement, or relationship with PeaceHealth may be terminated, and unless PeaceHealth has agreed to alternative arrangements with my employer, PeaceHealth may take legal action directly against me to both protect the Confidential Information and for damages caused to PeaceHealth and PeaceHealth's patients. Unless otherwise agreed to by PeaceHealth and my employer, specific actions against me can include termination of my employment, loss of my medical staff privileges, termination of my access to PeaceHealth information systems, termination of my contract or other terms of affiliation, and civil and/or criminal liabilities and penalties.

I understand and agree that I am solely responsible for knowing, understanding, adhering to, and complying with the terms of this Agreement. I **confirm** that the information provided on this application is true and complete to the best of my knowledge.

First Name (*please print*) MI	Last Name *(please print)*
Written Signature or Certified Electronic Signature	Date
Signature of Legally Responsible Person *(Required if the above individual is under age 18)*	*Date*