



University of Miami Hospital is excited that you will be observing at our facility. In order to make your observership a rewarding one, the following list of items have been compiled which is necessary for you to observe at the University of Miami Hospital.

**Required Document Check List for Observers at the
University of Miami Hospital:**

RELEVANT FORMS:

- Observer Application Form (attached)
- Confidentiality Agreement (attached)
- Observer Policy (attached)
- Expectations of Observer (attached)
- Copy of Government Issued Picture ID (Driver's License, passport, etc.)
- Proof of Immunization
- HIPAA Training Certificate
(<http://privacyoffice.med.miami.edu/documents/hipaa/index.html>)
- Curriculum Vitae (if applicable)
- Copy of Medical Licensure (if applicable)

Once you have completed the required paperwork please submit to the Medical Staff office. You can contact Medical Staff at 305-689-5407 to schedule an appointment for submission of these items and to receive your University of Miami Hospital ID badge. You will need this badge before you start your rotation.

Date Received

Date Approved:

Approved By:

APPLICATION FOR OBSERVERSHIP

PURPOSE:

1. To provide guidance to individuals requesting to observe physicians, Allied Health care Providers and Community Health care Representatives delivering patient care in the hospital setting. This type of observation will be referred to as “shadowing”.
2. To ensure that the confidentiality of health information is maintained.
3. To ensure that patients are not exposed to communicable disease.
4. To ensure that the observer does not provide any patient care.

PROCEDURE:

1. Observer shall request permission in advance from the physician they wish to shadow.
2. Observer shall notify Medical Staff Services of the intent to shadow.
3. Prior to receiving permission to observe the participant shall:
 - a. Complete application to observe
 - b. Designate the scope, date and duration of experience
 - c. Provide proof of immunization
 - d. Sign a confidentiality agreement
 - e. Secure a signed observer agreement
 - f. Agree to not provide any patient care
 - g. Assure patients consent to the presence of the observer

PREROGATIVES:

1. Medical Staff Services shall retain the right to refuse permission to an Observer who has requested a shadowing experience.
2. Observers are not permitted to discuss protected health information with anyone other than the person they are shadowing. Observers are not permitted to use or disclose protected health information
3. Staff being observed is asked to minimize the amount of protected health information they disclose to the observer.
4. Observer is to not perform any direct patient care
5. When an observer is in attendance in a clinical situation involving examinations, procedures or treatments they must secure the patients consent to be present. Consent is sought without the observer present so that patient is given every opportunity to refuse.
6. Terms of this agreement are limited to three months

EXPECTATIONS OF OBSERVERS:

Listed below is what is expected of you when you observe at UMH:

DEFINITIONS:

Staff being observed means a physician (MD, DO, DMD/DDS or Podiatrist) or Allied Health care Provider who is currently credentialed as a courtesy or active medical staff member of University of Miami Hospital who had agreed to accept an observer in their workplace.

Observer means an individual who is an adult (**18 or older**) who is

- currently enrolled in an either a Physician Assistant, Physician, ARNP training programs, or
- considering making application to a Physician Assistant, Physician, ARNP training program who meets criteria, or
- licensed providers who request to observe medical staff for specific clinical care, or
- currently enrolled in an educational program and desires to shadow physicians, or
- an employee who wishes to observe medical staff for specific clinical care and has completed all the documentation requirements associated with this policy*, AND
- Has an agreement with a medical staff member to observe under this policy.

***Any employee who shadows a physician under this policy is on unpaid time off.**

THIS APPLICATION MUST BE COMPLETED IN ENGLISH

(Please write legibly to be sure we have your correct information)

FULL NAME: **FIRST** **MIDDLE** **LAST**

ADDRESS: **CITY** **STATE** **ZIP**

PHONE NUMBER: **CELL PHONE:**

DATE OF BIRTH: **PLACE OF BIRTH:**

OBSERVED PHYSICIAN:

FULL NAME: **SPECIALTY** **PHONE #**

FULL NAME: **SPECIALTY** **PHONE #**

LENGTH OF OBSERVERSHIP (MAX ALLOWED 3 MONTHS): _____
(Please include dates)

PURPOSE OF OBSERVER: _____

DETAILED PROGRAM OF ACTIVITIES IN EACH SPECIALTY AREA: _____

OBSERVER POLICY

In exchange for the opportunity to participate in this observership, the following terms shall apply:

1. Observer will be observing a physician who is credentialed to provide patient care at the University of Miami Hospital.
2. In any communication to others at the University of Miami Hospital; Observer agrees to represent his/her status accurately as that of an Observer.
3. **Observer will NOT provide direct patient care to patients during the observership. Observers may not touch the patient or manipulate any equipment used in patient care.**
4. Observer understands that medical care includes, but is not limited to performing any of the following functions: take a medical history; perform a physical examination; diagnose or treat a patient's condition; prescribe or administer drugs; write notes or orders in a patient's chart; perform or assist in a surgical procedure; or bill for services rendered.
5. Observer agrees to wear an observer badge with photo identification as provided by the University of Miami Hospital, identify him/herself to patients as an observer, and observe patient care activities/procedures only after the patient has given permission for the Observer to be present.
6. Observer agrees to comply with all applicable policies and procedures of the University of Miami Hospital, including but not limited to policies on observer/visitor rules, equal opportunity/non-discrimination and protecting patient confidentiality.
7. To respect patient's confidentiality. Observer will not disclose or discuss patient identifiable information with any persons except with other healthcare providers involved in the patient's care as needed to facilitate the observership experience.
8. University of Miami Hospital may terminate Observership at any time, with or without cause.
9. To conduct yourself in a professional courteous and responsible manner.
10. To understand that clinical practice involves situations that will require a degree of sensitivity to the need of the patient and the obligation of the physician.
11. To dress appropriately when shadowing by adhering to University of Miami Hospital dress policy.

- 12. To realize that the physician is volunteering his/her time and has a demanding schedule.
- 13. To contact physician one week before the shadowing to confirm dates, times and objectives.
- 14. To call physician in advance if an emergency arises and you are unable to be there.
- 15. To secure patient's permission prior to entering a clinical situation involving treatment, procedure or examination.
- 16. Not participate in observation if ill, have fever or cough.

Please sign acknowledging that you have ready and understood this policy:

Observer Signature

Date

Observed Physician(s):

I hereby agree to be responsible for _____ who is observer here at UMH.
 _____ will not perform any procedures and will follow the guidelines set forth in the Observership policy.

Signature

Date

Signature

Date

Observer Statement:

I hereby certify that all documentation submitted is true and accurate to the best of my knowledge.

Signature

Date

CONFIDENTIALITY & SECURITY AGREEMENT

I understand that the facility or business entity (the "Company") in which or for whom I work, volunteer or provide services, or with whom the entity (e.g., physician practice) for which I work has a relationship (contractual or otherwise) involving the exchange of health information (the "Company"), has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their patients' health information. Additionally, the Company must assure the confidentiality of its human resources, payroll, fiscal, research, internal reporting, strategic planning, communications, computer systems and management information (collectively, with patient identifiable health information, "Confidential Information").

In the course of my employment / assignment at the Company, I understand that I may come into the possession of this type of Confidential Information. I will access and use this information only when it is necessary to perform my job related duties in accordance with the Company's Privacy and Security Policies, which are available on the Company intranet (on the Security Page) and the internet (under Ethics & Compliance).

I further understand that I must sign and comply with this Agreement in order to obtain access to Confidential Information.

1. I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know it.
2. I will not in any way divulge copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized.
3. I will not discuss Confidential Information where others can overhear the conversation. It is not acceptable to discuss Confidential Information even if the patient's name is not used.
4. I will not make any unauthorized transmissions, inquiries, modifications, or purging's of Confidential Information.
5. I agree that my obligations under this Agreement will continue after termination of my employment, expiration of my contract, or my relationship ceases with the Company.
6. Upon completion, I will immediately return any documents or media containing Confidential Information to the Company.
7. I understand that I have no right to any ownership interest in any information accessed or created by me during my relationship with the Company.
8. I will act in the best interest of the Company and in accordance with its Code of Conduct at all times during my relationship with the Company.
9. I understand that violation of this Agreement may result in disciplinary action, up to and including termination of employment, suspension and loss of privileges, and/or termination of authorization to work within the Company, in accordance with the Company's policies.
10. I will only access or use systems or devices I am officially authorized to access, and will not demonstrate the operation or function of systems or devices to unauthorized individuals.
11. I understand that I should have no expectation of privacy when using Company information systems. The Company may log, access, review, and otherwise utilize information stored on or passing through its systems, including e-mail, in order to
12. Manage systems and enforce security.
13. I will practice good workstation security measures such as locking up diskettes when not in use, using screen savers with activated passwords appropriately, and position screens away from public view.

Signature

Date