UW Medicine

APPLICATION AND AGREEMENT FOR OBSERVATIONAL ACTIVITIES

Please fill out completely. Incomplete forms cannot be processed.

Name:	Degree:		Day Phone:
Address:			Evening Phone:
City:	State:	Zip:	Email:
School (if applicable):		Grade level:	Career / Study interest:

I am 18 years of age or older ☐ Yes ☐ No, I am years old

Current Job Title: Company Name:

Address:_____ Phone Number:_____

Have you ever been convicted of a felony? ☐ Yes ☐ No

Have you ever had a license revoked or denied? ☐ Yes ☐ No

Select one of the following:

☐

☐ I have made specific arrangements with a UW Medicine employee and have been approved for an observational experience. Approved by:

Name:	Title:
Dept/Unit:	Phone:
Dates/times approved:	

Reason for being in the UW Medicine Area

A. I am a medical professional(e.g. physician, ARNP, PA, Nurse, Medic, health professions student) seeking additional experience

B. I am a medical professional(e.g. physician, ARNP, PA, Nurse, Medic) seeking to observe at the invitation of the person signing below for the purpose of mutual sharing of clinical, teaching and / or research.

C. I am employed by a commercial vendor and am participating in the development or conduct of collaborative research with the person signing below:

D. I am employed by a commercial vendor and am providing specific training to the person signing below and his / her staff.

E. Other: Please explain in detail.

Date(s) of Observational Activity:

I understand the observational activity provided is done as a public service in the interest of medical education.

I understand that all information about patients, whether it is medical or personal, is absolutely confidential. I have read and signed the confidential acknowledgement form listed on the back of this page.

I understand that as an observer, regardless of background and training, I may not perform any medical procedures. I will not have direct contact with patients, nor have unsupervised access to patients.

I agree to the following statements:

- My required immunizations are current and I have attached my immunization records.
- I have not had any exposure to measles, rubella or chickenpox in the last 30 days.
- If this observational assignment lasts more than 3 weeks, I will report to the UW Medicine Entity's Employee Health office for a Tuberculosis screening.

I agree to hold harmless the University of Washington and UW Medicine from any present and future liability and/or damages for injuries arising from or growing out of this observational experience.

Signature of applicant: *Date:*

Parental Permission for Minors (for applicants under 18 years of age)

My daughter/son has permission to participate in a UW Medicine observational experience and I authorize UW Medicine to administer a Tuberculosis test as deemed necessary. I understand the above statements and verify the information is accurate and complete.

Signature of Parent or Guardian: *Date:*

NON MEDICAL STAFF OBSERVATIONS

I understand that I will be responsible for this person for the duration of this observational activity.

Name of UW Medicine employee host:	*Date:*
Signature:	*Work Phone:*

MEDICAL STAFF OBSERVATIONS

I know this applicant and based on my knowledge of this applicant, his/her training, current competence, and health status as it affects performance, I attest that this person is physically and mentally competent to observe in the UW Medicine Clinics or other UW Medicine areas, and is observing for the purpose of medical education, research or training. I attest that the purpose of this is not solely for the benefit of a commercial vendor. I also attest that I will receive the permission of the patient(s) for this person to observe.

A. The person observing will be in my presence at all times: yes no

B. If no, please explain who will supervise the person observing?

The supervising Physician should introduce the visitor to patients.

Signature:	*Date:*
Supervising Physician	
Temporary Observation Privileges are Granted:	
Signature:	*Date:*
Medical Director	

Confidentiality Acknowledgement Form for Observational Activities

UW Medicine has a legal and ethical responsibility to safeguard the privacy of all patients and protect the confidentiality of their protected health information (PHI). Strong federal and state laws govern the privacy of our patients and their health information.

When you participate in an observational experience at UW Medicine, you are involved in a unique experience. You will be accompanying a health care professional for a specified period in a health care facility. During this time you will or may be seeing patients with a variety of medical issues and/or you may see and hear confidential information relating to these patients. This relates to information past, present and future.

As a condition of participating in this observational experience, I understand and agree that:

- I must maintain and safeguard the confidentiality of any and all UW Medicine protected health information.
- I will not access, use or disclose protected health information unless specifically approved as part of my observational experience. I will maintain all protected health information in the strictest confidence and will not disclose or allow access to protected health information to others.
- Any access to protected health information may be monitored to assure appropriate compliance with system integrity and UW Medicine policies and procedures.
- If I fail to comply with the above confidentiality guidelines, or if I breach patient confidentiality, this agreement will be terminated and my ability to participate in future activities at UW Medicine may be denied.

Signature of applicant/student:	*Date:*

☐ Temporary UW Medicine Entity Badge issued.

HMC Photo Identification Badges Policy 125.6	
UWMC, please contact the Public Safety Office at 598-4906	
Signature of applicant/student:	*Date:*

Persons involved in observational activities in patient care areas at UW Medicine must complete the UW Medicine Immunization Health History form.