LifeStyle Centre
Observer Application and Orientation Process

Complete/Produce the eight required documents below:

1. **Click on the following link or copy/paste the link into your web browser for the Non-Employee Education Materials. http://education.covhs.org/player.html**
    - **Print/sign the *Confidentiality and Release of Information* form at the end of this training and return with the packet.**
2. **Observer Data Sheet**
3. **Signed Observer Guidelines**
4. **Obtain Supervising Preceptors signatures with Inclusive Dates of the Observation on the Preceptor Agreement Form.**
5. **Documentation of tuberculosis test (TB TEST) taken within the past year, or completed symptom review form and recent chest X-ray report if you are a positive reactor.**
6. **Documentation of current-year influenza immunization.**
7. **Read and sign the Confidentiality Statement.**
8. **Current Professional Picture (JPG format) for your Covenant Badge**

You will be contacted by Natalie Bryant upon approval of your application to arrange an orientation with you. If you are observing surgeries, you will need to attend both a Covenant Orientation as well as an OR Orientation.

NOTE: Please submit your completed application packet (8 items above) by email to natalie.bryant@stjoe.org or by fax to 806-723-7146.

OBSERVER DATA SHEET

You must be 18 years of age or older and be enrolled in a post high school health professions program, a residency/fellowship, or be a licensed physician in order to request observation privileges.

Submit completed application and all supplemental documents to Medical Staff Services by email to natalie.bryant@stjoe.org or fax to 806-723-7146.

Allow two weeks for processing prior to start of Observation. You may not begin your observation without a Covenant badge and attending Orientation.

I am requesting Observation privileges as a (select one):
☐ Pre-med student ☐ Non-TTUHSC Resident ☐ Physician Observer ☐ Medical Student – Year ____
☐ Health Careers Student (i.e. CSA, NP, PA, CCP, Nurse) ☐ Other _____

Full Name: _____
First Middle Last Credentials (RN, BSN, ST, CST, etc.)

Date of Birth: _____ ☐ Male ☐ Female
Month Day Year

Home Address: _____

Cell Phone: _____ **Email Address:** _____

Current Education and School Supervisor Contact:

Name of School _____

School Address: _____

School Contact: _____ Phone: _____

Contact email: _____ Fax: _____

Supervising Preceptor(s):

Name _____ Observation Dates _____

Name _____ Observation Dates _____

Name _____ Observation Dates _____

Name _____ Observation Dates _____

Where will your Observation take place? ☐ CMC ☐CCH ☐ CMG Clinic ☐ Non-CMG Clinic
Are you currently employed by Covenant Health? ☐ Yes ☐ No Which campus? _____
Will any rotation you have involve a surgical specialty physician and require OR access? ☐ Yes ☐ No

If YES, what is your Scrub Size? _____

GUIDELINES FOR MEDICAL STAFF OBSERVERS AT COVENANT HEALTH

1. **Permission to observe a Medical Staff member of Covenant Health (Covenant Medical Center, Covenant Children's Hospital, Covenant Specialty Hospital, Joe Arrington Cancer Research and Treatment Center, Covenant Hospital Levelland, Covenant Hospital Plainview, Covenant Surgery Centers, and/or any of the Covenant Medical Group Clinics) is given as a public service to further interest in healthcare careers.**

2. **Observers may not provide any services related to provision of medical care to patients including, but not limited to: diagnosing diseases, administering medications, performing surgical procedures, suturing, providing medical advice or any other tasks generally reserved for the trained health professional. The only exception to this policy is with the second year medical students. MS2 students during their Community Preceptorships are allowed to gather a patient's history, administer a physical exam, document a patient visit and generate a basic differential diagnosis and plan for the patient condition.**

3. **Photography of any kind is strictly forbidden in any patient care area or other location that could violate patient confidentiality.**

4. **Observers must remain with the Supervising Physician at all times while in patient care areas of the hospitals.**

5. **Patients have the right to refuse to have Observers present for any examination, procedure, test or surgery.**

6. **Everyone must wear a Covenant badge above the waist in a visible manner at all times while on Covenant Health premises.**

7. **Observers must dress in attire consistent with Covenant Health policies and procedures.**

8. **Observers must maintain strict confidentiality and privacy in accordance with hospital policies and procedures and the Health Insurance Portability and Accountability Act (HIPAA).**

I have read and agree to abide by the Guidelines for Observers at Covenant Health. To the best of my knowledge, all information I have supplied is accurate and complete. I hereby release and hold harmless Covenant Health and all of their related and/or affiliated entities along with their respective directors, officers, representatives, agents, licensees, and/or employees, of any and all liability, damages, causes of action, suits, claims or judgments relating to my participation at Covenant. This release and hold harmless shall be binding upon me and my heirs, executors, administrators and assigns.

Observer Signature _____ Date _____

SUPERVISING PRECEPTOR AGREEMENT

I agree that the Observer's presence with me shall be <u>for the purpose of observation only, and that he/she may not perform any procedures, either in assistance with me or individually.</u> Observer agrees that he/she shall respect the wishes of any patient who objects to his/her presence and that he/she shall abide by the policies and procedures of Covenant Health (Covenant Medical Center, Covenant Children's Hospital, Covenant Specialty Hospital, Joe Arrington Cancer Research and Treatment Center, Covenant Hospital Levelland, Covenant Hospital Plainview, Covenant Surgery Centers, and/or any of the Covenant Medical Group Clinics), and comply with the provisions of the Health Insurance Portability and Accountability Act. I also understand that I must have the Instruction and/or Supervision of NP/PA/Medical Students, Residents and Fellows Privileges within the Covenant Health System in order to participate in this student's clinical rotation. (If you are not sure if you have Instruction Status, please contact Medical Staff Services 775 – 0566.)

I agree that I shall be responsible for all of the Observer's acts and omissions while he/she is with me at Covenant. I hereby release and hold harmless Covenant Health and all of their related and/or affiliated entities along with their respective directors, officers, representatives, agents, licensees, and/or employees, of any and all liability, damages, causes of action, suits, claims or judgments relating to Observer's participation with me at Covenant. This release and hold harmless shall be binding upon the Observers and my heirs, executors, administrators and assigns.

1.) _____ _____
Signature of Supervising Preceptor **Inclusive Dates of Rotation**

_____ **Specialty: ☐ Medicine ☐ Surgery**
Printed Name

Observer will rotate with me at: ☐ CMC ☐CCH ☐ CMG Clinic ☐ Non-CMG Clinic ☐ Cath Lab

☐ Other - _____

2.) _____ _____
Signature of Supervising Preceptor **Inclusive Dates of Rotation**

_____ **Specialty: ☐ Medicine ☐ Surgery**
Printed Name

Observer will rotate with me at: ☐ CMC ☐CCH ☐ CMG Clinic ☐ Non-CMG Clinic ☐ Cath Lab

☐ Other - _____

3.) _____ _____
Signature of Supervising Preceptor **Inclusive Dates of Rotation**

_____ **Specialty: ☐ Medicine ☐ Surgery**
Printed Name

Observer will rotate with me at: ☐ CMC ☐CCH ☐ CMG Clinic ☐ Non-CMG Clinic ☐ Cath Lab

☐ Other - _____

(Make copies of this page as needed for additional Supervising Preceptors)

CONFIDENTIALITY STATEMENT

(For Students/Observers/Volunteers)

As a student, observer or volunteer performing duties at Covenant Health (CH), you will have access to the protected health information (PHI) of patients. Federal and State laws, including HIPAA and other policies and procedures created internally, protect the privacy and security of this PHI, including the fact that an individual was a patient at CH. It is illegal for you to use or disclose PHI outside the scope of your duties at CH. This includes oral, written, or electronic uses and disclosures. Below are some guidelines that you must be familiar with regarding the use of a patient's PHI.

1. **You may use PHI as necessary to carry out your duties as a student/volunteer;**
2. **You may share PHI with other health care providers within CH for the direct treatment of the patient;**
3. **You may NOT photocopy or otherwise permit PHI to be duplicated in any way;**
4. **You may NOT photograph patients;**
5. **You must access only the minimum amount of PHI necessary to care for a patient or to carry out an assignment;**
6. **You may NOT record PHI (such as patient names, diagnoses, dates of birth, addresses, phone numbers, Social Security numbers, etc.) on any assignments you may need to turn in to your instructor, reports you may need to turn in to your program, or forms you may need to take with you;**
7. **You may only access the PHI of patients for whom you are caring/volunteering when there is a need for the PHI;**
8. **You must be aware of your surroundings when discussing PHI. As an example, it is inappropriate to discuss PHI in elevators, bathrooms, the cafeteria, and any other place for which your discussion may be overheard;**
9. **When disposing of any documents with PHI, do NOT place them in the trash can. Instead, the documents should be placed in the proper containers marked for shredding or another disposal container as set forth by policy and procedures for your specific department;**
10. **If you have questions about the use or disclosure of PHI, contact Natalie Ramello (806.725.0085).**

Please read, sign, and date this acknowledgement. Return it Medical Staff Services where it will be filed with your application.

Acknowledgment

I have read and I understand the information in this document. I realize that there are penalties for which I may be subject, including criminal, for the unauthorized use and disclosure of PHI. I agree to abide by the guidelines described above when performing my duties at Covenant Health.

I understand and agree that in the performance of my duties within any Covenant Health entity (Covenant Medical Center, Covenant Children's Hospital, Covenant Specialty Hospital, Joe Arrington Cancer Research and Treatment Center, Covenant Hospital Levelland, Covenant Hospital Plainview, Covenant Surgery Centers, and/or any of the Covenant Medical Group Clinics) I may become aware of information that could be considered confidential. It is my responsibility to protect the privacy of patients, employees and the hospital. I understand that my failure to comply may result in disciplinary action from my physician supervisor.

Name (Print): _____ **Date:** _____

Signature: _____