OBSERVATION REQUEST FORM – PRE CLEARED OBSERVERS

(Including, but not limited to an ECHN employee, volunteer, contracted student or other healthcare professional who may have current documentation and screening requirements on file)

TO BE COMPLETED BY SPONSOR

ECHN FACILITY	
DEPARTMENT/AREA BEING OBSERVED	
AREA TYPE	☐ Operating Room ☐ Clinical Setting ☐ Non-Clinical Setting
SPONSOR NAME	
SPONSOR PHONE NUMBER/PAGER	
SPONSOR CONFIRMS THEY ARE AN ECHN EMPLOYEE	☐ YES
OBSERVER NAME	
OBSERVER DATE OF BIRTH **All observers must be at least 16 years of age.**	
OBSERVER PHONE NUMBER	
PRE-CLEARANCE TYPE ***(If the observer has completed clearance documentation (e.g., health screening, physical, etc.) for another reason please specify what type)***	☐ Employee ☐ Contracted Student ☐ Volunteer ☐ External Healthcare Professional ☐ Other (specify):
ESTIMATED START/END DATES	START: END:

Eastern Connecticut Health Network ("ECHN") supports individuals, herein referred to as "Pre-cleared Observers," who desire to gain and/or impart medical knowledge during the observation of patient care procedures and activities at ECHN. These Pre-cleared Observers have fulfilled screening/clearance requirements under other programs or through employment, but wish to observe in another area outside of their experience, contract or employment agreement. In exchange for this observational experience, the Pre-Cleared Observer agrees to abide by the following terms during the observation period.

ECHN Sponsor Statement and Signature:

As an ECHN employee and/or member of the Medical Staff with appropriate credentials, I endorse this applicant to be approved for an observation at the ECHN Facility listed above. This applicant will be under my *full* supervision for the duration of the observation. I have received this application and by signing below, I agree to the following:

- I agree to personally oversee and supervise this individual for the approved duration of this observation, at all times, regardless of their employment, credentials or experience and have notified and obtained approval from my supervisor or the respective provider(s) who may come in contact with this individual.
- I will ensure the applicant will abide by all ECHN policies and procedures and all federal and state rules and regulations including those pertaining to HIPAA, patient confidentiality, infection control and safety.
- I understand that the applicant will only be permitted to view patient care with the consent of the patient and any other provider involved in the care of the patient, and I will identify the applicant to all patients and providers as an observer.
- I agree that the applicant will have no direct patient contact or provide any type of medical care or consultation, regardless of licensing or credentials.
- I understand that prohibited independent medical care includes, but is not limited to, performing any of the following functions: taking a medical history; separately performing a physical examination; diagnosing or treating a patient's condition; prescribing or administering drugs; writing notes or orders in a patient's chart; performing or assisting in a surgical procedure; or billing services rendered.
- I will ensure the applicant does not enter isolation rooms and will not participate in an observation when he/she is sick, has a fever or has been exposed to a contagious disease.
- I will report any violation of ECHN policies, procedures, rules and regulations by the applicant to the appropriate department.

______________________________ ______________________________ ____________

Sponsor PRINT NAME **Sponsor SIGNATURE** **Date**

______________________________ ______________________________ ____________

Supervisor of Sponsor PRINT NAME **Supervisor of Sponsor SIGNATURE** **Date**

Eastern Connecticut Health Network, Inc.

Applicant Disclaimer and Signature:

By signing this application,

- I understand that regardless of my employment, credentials or experience I must be accompanied by my sponsor, or their designee and follow all directions at all times throughout my observation.
- I understand that during performance of my observation, I will not be considered an employee or affiliate of ECHN or any independent physician group providing services to ECHN, regardless of my status outside the hours of this observation.
- I understand that that I will not be entitled to salary, benefits, reimbursement of expenses or other compensation during the hours of my observation, regardless of my status outside the hours of observation.
- Prior to the start of the observation period, I will provide any documentation that is requested of me which is not currently in my file.
- I understand that this observation will be hands-off and I will not be permitted to engage in patient care, of any kind.
- I understand that I will **NOT** be allowed independent access to patients or a patient's medical record (hard copy or electronic) while in my observational role.
- I understand that this observation will be at the patient's discretion and that if a patient is not comfortable with my presence as an observer, I must leave the patient care area.
- I understand 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 regardless of the licensure or credentials I may have.
- I understand that through my sponsor, I will be expected to follow all ECHN policies and procedures as well as all federal and state rules and regulations, including those pertaining, but not limited to HIPAA, patient confidentiality, infection control and safety.
- I will not disclose or discuss patient information with any persons except with my sponsor or other healthcare providers involved in the patient's care, as needed, to facilitate the observation experience, I also understand that my duty to protect this information extends beyond the end date of my observation.
- I agree to refrain from observing if I feel unwell or have an infectious disease or condition that could be transmitted.
- I understand that if I breach any policy, procedure, rule or regulation my permission to act as an observer will be withdrawn and I may be asked to leave immediately.
- ECHN may terminate the observation experience at any time and in its sole discretion by providing notice to the observer.
- I acknowledge that ECHN does not discriminate based on any protected characteristic under federal and state law and that no observation will be cancelled or postponed due to or related to any protected characteristic, therefore, no appeal or grievance rights exist to challenge the termination of an observation experience.
- I certify that my answers on this application are true, to the best of my knowledge. I also understand that I am responsible for completing all necessary clearance requirements and assume responsibility for all associated costs, prior to beginning my observation.

PRE-CLEARED OBSERVER:

______________________________	______________________________	____________
Signature	Print Name	Date

If Pre-Cleared Observer is under the age of 18, parental consent is required:

______________________________	______________________________	____________
Parent/Legal Guardian Signature	Parent/Legal Guardian Print Name	Date

Sponsor, please submit this form to: observations@echn.org

*****PLEASE NOTE: COMPLETION OF THIS FORM ALONE DOES NOT INDICATE THE OBSERVER HAS MET ALL REQUIREMENTS. THIS IS A PRELIMINARY INTEREST FORM ONLY. OBSERVERS SHOULD NOT BE ALLOWED TO OBSERVE UNTIL THE RESPECTIVE SPONSOR HAS RECEIVED COMMUNICATION FROM THE OBSERVATION COORDINATOR THAT ALL PAPERWORK HAS BEEN RECEIVED*****

APPROVED BY COORDINATING DEPARTMENT, OR DESIGNEE:

______________________________	______________________________
Signature	Print Name
______________________________	______________________________
Department/Area	Date

Clearance Requirements ***(To be Completed by Coordinating Department)*****:**

☐ Confirmed Pre-Clearance Status with Departmental Designee:

Departmental Designee: ______________________________ Date Confirmed: ________________________