Eastern Connecticut Health Network, Inc.

OBSERVATION REQUEST FORM-STUDENTS

Personal Information of Candidate-Observer:			
Last Name:	**First Name:**		**M.I.:**
Street Address:		**Apt/Unit#:**	
City:	**State:**	**Zip Code:**	
DOB *(MM/DD/YYYY)*: **All Observers must be at least 16 years of age*	**Email Address:**		
Primary Phone Number:	**Alternative Phone Number:**		
Emergency Contact:	**Relationship:**	**Phone Number:**	
Current or Former ECHN Employee or Volunteer?:			
Do you have a close family relative who works for ECHN? ☐ YES ☐ NO			
Please Indicate Observer Type: ☐ High School Student ☐ College/University Student			

School Information:	
Current Academic Year:	**Major (if applicable):**
Name of School:	**Expected Graduation Date:**

Request Details

Specify the statement the best fits your request:

☐ I am requesting to observe due to a **required** experience for my future school or program participation

(e.g., high school student needing Physical Therapy (PT) observation hours to apply to a college PT program)

College/University Students Please Note: This observation request is <u>not</u> to be used for course credit. If you are seeking course credit or placement to fulfill course credit please have your educational institution speak to the ECHN Legal Department to confirm a Student Educational Affiliation Agreement is in place.

☐ I am requesting to observe for my own personal experience to obtain insight into a future career field

☐ Other, please specify:

Applicant Disclaimer and Signature:

By signing this application,

- I understand that I must be accompanied by my sponsor and follow all directions at all times.
- I understand that I will not be entitled to salary, benefits, reimbursement of expenses or other compensation during the hours of my observation.
- 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 **<u>NOT</u>** be allowed access to a patient's medical record (hard copy or electronic).
- 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.
- 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 or procedure of ECHN or any federal and/or state 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.

_____	_____	_____
Applicant PRINT NAME	**Applicant SIGNATURE**	**Date**
_____	_____	_____
Parent/Legal Guardian PRINT NAME	**Parent/Legal Guardian SIGNATURE**	**Date**

Parent or Legal Guardian must sign if applicant is under the age of 18.

ECHN
Eastern Connecticut Health Network, Inc.

For Completion by ECHN Sponsor:		
Last Name:	**First Name:**	**M.I.:**
Title:	**I confirm that I am an ECHN employee:** ☐ YES	
Location of Observation:		
Department(s)/Area(s) of Observation:		
Is the student approved to observe patients? ☐ YES ☐ NO		
Email Address:	**Phone Number:**	
Applicant Approved for the Following Date Range (MM/DD/YYYY) **START DATE:** **END DATE:** **Total Hours:**		

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. I understand that I must receive confirmation from the Observation Coordinator confirming all paperwork has been received and reviewed for the Observer. Neither I, nor my respective department, will allow an Observer to come on-site until I have received this documented approval. 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 and have notified and obtained approval from my supervisor.
- I will ensure the applicant will abide by all ECHN policies and procedures as well as 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.
- 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**

*****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*****

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

CLEAR FORM