

OBSERVER APPLICATION

This form should be submitted at least 24 hours prior to potential observance.

Name: _____

Organizational affiliation (if applicable): _____

Address: _____

Telephone: _____ Email: _____

Date of Proposed Visit: _____

Hours/Duration of Proposed Visit: _____

Purpose of Proposed Visit: _____

BH Facility Department(s) Visiting:

Sponsor of Observer: _____

Phone: _____ Email: _____

Department Director(s) decision on application to observe:

Department: _____ Director: _____

Approved or Denied

Reason for decision: _____

Practice Administrator/Executive Director decision on application to observe:

Department: _____ Signature: _____

Approved or Denied

Reason for decision: _____

Administration, or designee decision on application to observe:

Name: _____ Signature: _____

Approved or Denied

Reason for decision: _____ Date: _____

OBSERVER CONFIDENTIALITY AGREEMENT

Name: _____

Organizational affiliation (if applicable): _____

Address: _____

Day-time phone: _____ Email: _____

If proposed Observer is a minor, name of the minor's parent: _____

Address, day-time phone number, and email if different from above: _____

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I understand that I may see or hear confidential patient information when I visit the BH facility. If I see or hear any information about BH facility patients, I will respect patient confidentiality and I will not share, discuss, or release that information to anyone else without the written permission of the BH facility.

I will not take any pictures while at the BH facility (including with my cell phone) and I will not make any audio or video records while at the BH facility.

I will follow all directions of BH facility personnel while I am a visitor at the BH facility. I will leave a patient care area, or the facility, immediately upon the request of BH facility personnel or physicians.

If I am visiting an operating room, I will not scrub in, enter a sterile field, open sterile products, touch a patient, participate in patient care, or operate equipment associated with a medical procedure.

I will not go anywhere in the BH facility without my Sponsor or an Escort by BH facility personnel.

I understand that if I do not follow these requirements, I may be asked to leave the BH facility and I may not be allowed to return.

***If I am the parent of the Observer, I am responsible for my child following these requirements. I will not allow my child to participate as an Observer unless I believe that my child understands and will follow these requirements.**

Signature of Observer

Date

*

If Observer is a minor, Signature of Parent

Date

SPONSOR OF OBSERVER AGREEMENT

Name of Observer I will sponsor: _____

As the sponsor of this Observer, I understand that I am responsible for the Observer's conduct in the BH facility.

I acknowledge:

The Observer may only observe. The Observer may not assist a healthcare provider in any way. If the Observer visits an operating room, he/she may not scrub in, enter a sterile field, open sterile products, touch the patient, participate in patient care, or operate equipment associated with a medical procedure.

The Observer must check in at the facility and be issued a badge prior to the Observation experience.

The Observer must be accompanied while in the BH facility.

I agree, as the Sponsor of the Observer, that I am responsible for the Observer's conduct in the BH facility. I will not allow the Observer to see or hear patient information except as permitted by the Privacy Rules, BH policies and procedures and as necessary for the purposes of the visit. I will not leave the Observer unattended without an Escort. I understand that if I do not follow these requirements, I may be subject to adverse personnel action of medical staff peer review.

Signature: _____ Date: _____

Print Name: _____