Appendix A

Observer/Job Shadow application

LCMC Health

Instructions:

- It is recommended **all** documents be completed and submitted at least 30 days in advance of Observer/Job Shadow requested start date.
- Incomplete/partial documents will not be processed.

The following documents must be completed and attached as part of the LCMC Health Observer/Job Shadow application:

- ◯ Observer/Job Shadow application, including LCMC Health requirements verification documentation
- ◯ Signed observer confidentiality agreement
- ◯ Signed statement of agreement and acknowledgment of roles and responsibilities
- ◯ Signed sponsor acknowledgment
- ◯ Signed observer code of conduct policy
- ◯ Copy of driver's license or legal photo ID

Personal information

First name:_____ Last: _____ Date of birth:_____

Are you a U.S. citizen? ◯ Yes ◯ No

Address:_____

City:_____ State:_____ Zip code:_____

Phone:_____ Email:_____

Anticipated start date:_____ Anticipated end date:_____

Emergency contact relationship: _____Phone:_____

Requested activities/duties/responsibilities during visit:

Requested hospital and dept/unit/specialty where observation will occur?_____

LCMC Health sponsor (employee or med staff member):_____

Health requirements

Requirements	Date(s):
A negative TB skin test or negative chest x-ray (within 12 months of the requested observation/shadowing date(s))	
Proof of 2 MMR vaccines or positive Rubella titer	
Proof of Hepatitis B vaccination series (1st, 2nd and 3rd); This can be proven by three (3) doses of Hepatitis B vaccine or with antibody-proven immunity. Signed declination of Hep B vaccination may be accepted.	
Proof of varicella vaccine or positive blood titer Documented history of chicken pox or herpes zoster is an acceptable alternative to proof of (2) varicella vaccines. If these vaccination are medically contraindicated, a physician note to this effect is required.	
Proof of Tdap vaccination, within 10 years	
Proof of COVID-19 vaccination If medical or religious exemption is approved, observer must wear surgical or respirator mask while in the facility.	
Proof of influenza vaccine (within past 12 months, if observing/shadow experience will occur between October 1–March 31)	
WHERE WILL OBSERVERSHIP OCCUR? (**Note: Observation / Shadowing is not permissible within the operating room, behavioral health units, offender care units, intensive care units, labor and delivery, or other specific hospital-designated high-risk units or departments unless specific approval has been granted by the hospital Chief Medical Officer (CMO) or designee)	
PURPOSE OF EXPERIENCE (describe rationale and purpose of request for experience in hospital)	

Health insurance information:		
Company name:	Policy #:	Group #:
Guarantor name:	Date:	

If the applicant will be under eighteen years of age at the time of the experience, a parent must sign permission below field

Permission is granted for _____to participate in a shadowing/observing.
(First and last name of student).Please print

Signature	Printed name	Date
_____	_____	_____

SPECIAL APPLICATION TO OBSERVE CRITICAL CARE / HIGH RISK UNIT:
(Note: Observation / Shadowing is not permissible within the operating room, behavioral health units, offender care units, intensive care units, labor and delivery, or other specific hospital-designated high-risk units or departments unless specific approval has been granted by the hospital Chief Medical Officer (CMO) or designee)**

At the time of the experience, I will be >16 years of age:	◯ Yes	◯ No
The date(s) requested are [note that no more than 5 work days are		
The provider directly responsible for my supervision during this time will be:	Provider specialty	
Chief Medical Officer name (please print)	◯ Approve	◯ Decline
Chief Medical Officer signature		

Observer Confidentiality Agreement

Name of observer: _____ Date:_____

I agree that I will not at any time during or after my observation period with LCMC Health, disclose any patient information, including demographic, medical, or other confidential information.

I understand that LCMC Health is committed to protecting patient privacy and confidentiality. I understand that the information that I as an observer am exposed to, is presented to me in a variety of media such as medical records, claims, computer systems, logs, and conversations.

I understand I may not take pictures of/audio record/video record any patients or of any documents during or after my observation experience.

I understand that medical records and other forms of medical information may not be removed from the hospital.

I share the commitment of LCMC Health to protect patient confidentiality and by my signature on this document, pledge compliance with the terms of the Confidentiality Policy and Confidentiality Agreement.

I understand that a person may be subject to civil or criminal legal sanctions when such violations occur.

I have read and had a chance to ask questions regarding this agreement. I understand the terms of this agreement and agree to adhere to them.

_____ _____

Observer signature Date

_____ _____

Sponsor signature Date

_____ _____

Parent/legal guardian signature Date

If observer is under the age of 18 years of age

Statement of Agreement and Acknowledgment of Roles and Responsibilities

LCMC Health

Observer: _____

Agreement: LCMC Health and its member affiliates, has agreed to allow the undersigned Observer to observe patient care or hospital services after meeting the established requirements and under the supervision of a designated sponsor. In consideration of the undersigned Observer being allowed the opportunity at LCMC Health, the undersigned Observer, hereby agrees to the following:

Confidentiality: The Observer agrees that any information or knowledge acquired or received during the course of the observation at LCMC Health including but not limited to patient care information and information contained in patient care records, shall be treated as confidential and shall not, unless required by law or otherwise permitted by LCMC Health, be disclosed or used during or after termination of the Observer placement at LCMC Health without the prior written consent of LCMC Health.

Release/Indemnification: The undersigned Observer agrees to and hereby does release, indemnify and hold harmless LCMC Health, its member affiliates, directors, officers, employees, and representatives from any and all responsibility and obligation, and agrees not to hold LCMC Health liable for any or all injuries, losses, damages or expenses which may occur as a result of any act or omission of LCMC Health, its member affiliates, directors, officers, employees, or representatives, or which may arise for the Observer's participation in the Observer Program.

Illness: The undersigned Observer hereby forever releases and shall discharge all claims and causes of action whatsoever, present and future, against LCMC Health, its directors, officers, employees, and agents, related to or arising out of any illness, disease, or health condition the individual may contract, develop or come into contact with while on the premises of an LCMC Health facility.

Medical treatment: LCMC Health shall provide or refer for outpatient treatment to Observers while in the facility for the Observer Program in the case of an accident or illness. However, under no circumstances shall LCMC Health bear the cost of the treatment.

LCMC Health hospital policy: The Observer agrees to conform to all policies and procedures including those related to safety, patient care, non-discrimination, Code of Ethics, The Joint Commission, CMS, and Occupational Safety and Health Administration (OSHA) requirements.

Clinical conduct: The Observer agrees to not participate in any direct clinical action, nor perform any task that would normally be performed by a healthcare worker. The Observer understands they may not observe invasive examinations or procedures. The Observer agrees to not document in the patient's medical record or any other depository of patient information. The Observer understands there may be restrictions in the areas/units of observation and their sponsor may be required to obtain special permission from the LCMC Health facility Chief Medical Officer (CMO) or designee for observations in high-risk areas.

Patient consent: The Observer understands that they may not observe patient care without the patient first consenting to the observing.

_____ _____

Observer signature Date

_____ _____

Sponsor signature Date

_____ _____

Parent/legal guardian signature Date

If observer is under the age of 18 years of age

Exhibit 1

Code of Conduct

LCMC Health

Acknowledgment

This is to acknowledge that I have read and understand the LCMC HEALTH Learner Code of Conduct. I hereby authorize LCMC Health and my school to communicate with each other as outlined in the Code of Conduct where necessary.

_____

Print name

_____ _____

Signature Date

LCMC Health