Complete form and submit to mhstudentplacement@uchealth.org

Name _____ Date _____

Address _____

Phone _____ Email _____

School _____

Course _____

Reason for Observation Request _____

_____

Observation Information

Provider Name _____

Provider Location / Address _____

Requested Observation Date _____

Has the named provider agreed to sponsor observation? ◯ YES ◯ NO

Confidentiality Agreement

As a Shadower, Observer, or Tour Group Member at Memorial Hospital, I have read and understand the above "HIPAA Awareness Training." I recognize the extreme importance of confidentiality with respect to the PHI of patients, as well as to Memorial Hospital operations. I acknowledge that I will adhere to the HIPAA provisions and any other federal or state laws regarding confidentiality.

I understand that for those persons who are "covered entities," violations of confidentiality may result in legal action pursuant to HIPAA and other applicable state and federal laws. All patient information (including personal, financial, and health information), as well as all information regarding Memorial Hospital operations, whether business, financial, or legal, is confidential. Any inappropriate viewing, discussion, or disclosure of this information, even to friends or family, may constitute a violation of state and federal law, and of Memorial Hospital policy. This information is privileged and confidential regardless of format: electronic, paper, overheard, or observed.

Release and Waiver of Liability

I wish to observe as a Shadower, Observer, or Tour Group Member the activities of health care professionals at Memorial Hospital in furtherance of my career. I understand that I will not be allowed to perform any clinical activities or other work, including the touching of any patients, documenting on any medical record and advising or providing care to any patient or family. I further understand that I will be under the supervision of the health care provider(s) I am Shadowing, and that this experience is limited to 20 hours or less.

I understand that I am not to be in any patient care area without a Memorial Hospital health care professional present with me. I understand that even though I will only be observing activities, I may be exposed to certain risk of bodily injury and other dangers, including but not limited to, exposure to blood-borne pathogens, biological waste and dangerous chemicals and instruments. I am aware of these risks and voluntarily assume these and any other risks. For and in consideration of Memorial Hospital allowing me to observe the activities of its health care professionals to further my educational, career, or other goals, I hereby release and forever discharge Memorial Hospital, and its officers, trustees, agents, and employees from all claims, demands, rights, and causes of action of whatever kind or nature arising from and by reason of any and all known, foreseen, and unforeseen bodily and personal injuries, death, or damage to property arising out of my observation activities, including but not limited to, those specific risks enumerated above.

I have read this document carefully and voluntarily choose to participate in Shadowing, Observing, or Tour Group Member activities at Memorial Hospital.

I hereby certify that I am at least 18 years of age, that I am legally competent and that I am signing this document with full knowledge of its significance.

Registrant's Printed Name	Registrant's Signature / Date