ATTACHMENT A

OBSERVATION APPLICATION FORM

PERSONAL INFORMATION

Name ______________________ Date of Birth (include year if under 18)

Home Address ______________________ City, State ______________________ Zip Code

Home Phone ______________________ Cell Phone ______________________ E-mail

Emergency Contact ______________________ Home ______________________ Work ______________________ Cell

PROJECT INFORMATION

Project area ______________________ Start date ______________________ End date ______________________ # of hours requested

Please describe why you are interested in doing an observation in this area:

I certify that the statements made in this Observation application are true and correct and have been given voluntarily. I understand that this information may be disclosed to any party with legal and proper interest, and I release the hospital from any liability whatsoever for supplying such information.

Signature ______________________ Date

****NOTE** IF YOU ARE UNDER THE AGE OF 18, A PARENT OR GUARDIAN MUST SIGN THE FOLLOWING STATEMENT OF CONSENT:**

I give consent for my daughter/son to participate in University Hospitals Observation Program. I authorize University Hospitals' physicians to administer medical treatment in case of emergency. I will encourage my daughter/son to be prompt and dependable in her/his service at University Hospitals. I understand that all UH observers are required to have a TB test and some areas may require additional health screenings.

Printed Name ______________________ Signature ______________________ Date

Please mail or fax completed application to:

Janice Glenn, Volunteer Services
University Hospitals Samaritan Medical Center
1025 Center Street, Ashland, Ohio 44805
Fax: 419-207-2603

ATTACHMENT B

SPONSOR FORM

(Hospital Staff Member)

Sponsor Contact Information

Department: ____ Phone__________________________

Supervisor/Contact Person: _________________________________ Phone__________________________

Person Student Observer Reports to: __________________________ Phone___________________________

Location:____ Room___________________________

Observer Information

Name____ Phone__________________________

Address____

City________________________________ Zip____________ Relationship to sponsor _________________

Please note, the minimum age for student observers in a patient care area is 16 and a junior in high school. Pediatric areas require the observer to be 17 and a senior in high school. The Operating room requires a higher minimum age of 18 and a senior in high school.

Observation Description

Start Date_______________________ End Date________________________ # of Hours_________________

Description of what student will observe and/or activities:____

____

____

____

I will follow the UH Observation Policy and will ensure the above student is supervised while they are on the Hospital campus. Also in accordance with this policy, I will assist the Observation Coordinator in contacting the above student and will ensure the student completes all procedures and paperwork prior to beginning the observation.

______________________	______________________	______________
Printed Name	Signature	Date

Please mail or fax completed application to:

Janice Glenn, Volunteer Services
University Hospitals Samaritan Medical Center
1025 Center Street, Ashland, Ohio
Fax: 419-207-2603

ATTACHMENT C

CONSENT FOR PARTICIPATION IN OBSERVATION PROGRAM AND CONFIDENTIALITY AGREEMENT

I understand that I/my child have/has been selected to participate in the Observation Program (the "Program") at University Hospitals Health System ("Hospital"). I understand that, in participating the Program, I/my child will be exposed to the normal risks of any hospital visitor, as well as possible additional risks that arise because I/my child will be in patient care areas and observing patient care.

I understand and agree that I waive, for myself, my child, and any heirs and/or assigns, any and all claims, including any negligence claims which I or my child might have against the Hospital, or its agents or representatives, in any way arising from or relating to the Program, except for claims arising out of the gross negligence or reckless or willful misconduct of Hospital or it agents, or representatives. I hereby agree that I will not sue Hospital on behalf of myself or my child, nor will my child sue on his/her own behalf, and release Hospital from any claims I/my child, may have against it except for gross negligence or willful or reckless misconduct on the part of Hospital, its trustees, officers, agents, and employees.

In the event of exposure to blood or other bodily fluids from a patient who is a carrier of a contagious or infectious disease or a patient who is, in the judgment of Hospital, at risk of carrying a contagious or infectious disease, Hospital shall, with my consent, administer immediate precautionary treatment to me/my child that is consistent with current medical practice without any further consent from me. I shall pay for the initial screening tests or prophylactic medical treatments should the need arise. Hospital shall have no responsibility for any further diagnosis, medication or treatment and I acknowledge and assume the risk of me/my child observing or being in the immediate presence of patients at risk of carrying a contagious or infectious disease.

I certify that I/my child has no known physical or mental illness or condition, including any contagious disease, which could be detrimental to the welfare or interfere with the care of any of Hospital's patients or staff. I certify that I/my child am/is currently covered by health care insurance or Medicaid and that it shall remain in effect through the end of my/my child's participation in the Program.

I understand that the Hospital will not provide transportation or meals for me/my child while I/my child participates in the Program and that these expenses must be borne by me.

I understand that the Hospital does not view this observational experience as an educational record and I/my child will be given no confidentiality considerations under the Family Educational Rights and Privacy Act ("FERPA").
I/my child will wear appropriate attire for this Program. Participants may not wear open toe shoes, sleeveless shirts, jeans, exposed midriffs, heavy perfume or cologne, dangling jewelry, or jewelry in tongue or face piercings. I/my child will not be permitted to remain at the Hospital unless dressed appropriately.

I understand the following:
Confidential means that something is to be kept private or secret; that it is not to be repeated to anyone or given to anyone.

Confidential Information means any and all information that I may learn about a patient at University Hospitals Health System. This information is automatically private or secret. Confidential information about a patient includes: name, address, diagnosis, medical information, medical notes, resumes, pictures, and medical records including x-rays and medicines, as well as any descriptive that could cause any person to become aware of the identity of a patient. Confidential Information also includes the name of any person at UH who is not a UH employee or volunteer, because all patients are not easily identifiable by where they are in UH or how they are dressed.

Disclosure means sharing or telling someone something I know about someone that is private or confidential.

Nondisclosure means not sharing or telling someone something. It means not to write, speak, or gossip about any patient I see or talk to at University Hospitals Health System.

Please read and sign on next page

ATTACHMENT C (cont.)

University Hospitals

Consent for Participation in Observation Program and Confidentiality Agreement

I understand that while I/my child am/is in the Hospital, I/my child may obtain Confidential Information about Hospital's patients. I understand for myself/I shall instruct my child that Program participants are to maintain in strict confidence all information and data relating to Hospital's patients, and shall not disclose such information to any third party, including any family member or friend, under any circumstances. Additionally, Confidential Information is not to be removed from the Hospital or discussed with other participants in the same Program. I understand for myself/I will instruct my child that patient confidentiality is of such great importance that it is never to be disclosed to anyone outside of the Hospital no matter how long after participating in the Program.

By signing this form I agree that I have read, understand, and agree to the terms in both pages of this consent form and confidentiality agreement, or, in the alternative, that I have read this form to my child and he/she understands and agrees to its terms. I give my full consent to my/my child's participation in the Observation Program at University Hospitals Health System.

Observer:

____
Print Name Signature of Observer Date

____
Street Address City/State/Zip

____
Name of School

Print full name and address of parent/legal guardian if different from Student:

____
Print Name Signature of Parent or Legal Guardian Date

____
Street Address City/State/Zip

ATTACHMENT D

OBSERVATION REVIEW MANUAL

CONFIDENTIALITY

As an observer, you are governed by the same code of ethics that applies to physicians, nurses, and all other hospital employees. Patients expect the hospital to keep their charts, medical information, and even the fact that they are in the hospital confidential. This understanding between the patient and hospital is an implied contractual agreement and is legally enforceable through HIPAA (the Health Insurance Portability and Accountability Act of 1996).

All observers are required to sign a statement about patient confidentiality (Attachment C) that becomes part of your permanent record.

Remember:

- Leave all patient information where it belongs: in the hospital
- You will be provided information concerning patients on a "need to know" basis only
- Do not leave written information unguarded. Destroy such materials before leaving the area
- To say anything about a patient is to say too much

INFECTION CONTROL

Hand washing is the single most effective method of preventing transmission of infections. Hand washing is a 15 to 30 second process. Use a paper towel to turn off the faucet after drying hands.

Observers should never enter a room of a patient who is in isolation unless authorized by a sponsor and then, only after the necessary precautions have been explained. It is important to always observe the signage on the door.

FIRE SAFETY

Use the word **SEE** for locating fire alarms and extinguishers: Stairwells, Exits, and Elevators
The term **CODE RED** means fire. For fire or medical emergency, call **x5555.**
The letters **RACE** tell you how to proceed in a fire emergency:

Rescue anyone in need and clear the corridors
Activate the fire alarm by pulling the alarm pull station and call **5555**
Confine smoke and fire by closing all doors
Exit the area of extinguish the fire only if you do it without danger to yourself

SECURITY

Security is on duty 24 hours a day, 7 days a week. If you see something suspicious or need assistance, use a hospital phone and dial x**2427 or** call the operator at #4444 **for assistance in contacting security.**

ATTCHMENT D (cont'd)

OBSERVATION REVIEW

Name____

Observation Area____________________________________

1. What procedure should you follow if you see smoke or fire?
   a) Race, Ask, Contact, Evaluate
   b) Pull, Activate, Send, Signal
   c) Rescue, Activate, Confine, Exit/Extinguish
   d) Pull, Aim, Squeeze, Sweep

2. What number would you call for the Hospital Police Department?
   a) 411
   b) 5555
   c) 4357
   d) 911

3. At UH, you would find a fire pull station or fire extinguisher near a(n):
   a) Elevator
   b) Exit Door
   c) Stairwell
   d) All 3 locations

4. **True or False**
   The single most important thing to do to reduce the risk of infection is hand washing.

5. You learn one of your neighbors is a patient. What can you tell other neighbors about his/her condition?

   ____

   ____

6. A patient is thirsty and asks you for something to drink. What should you do?

   ____

   ____

7. **True or False**
   Patient information is confidential and should not be shared. What you see here and hear here stays here when you leave here.

ATTACHMENT E

PATIENT CONSENT FOR PRESENCE OF OBSERVER

Students from local schools and select community members are participating in the University Hospitals Health System Observation Program (the "Program"). The Program is designed to teach individuals about healthcare and healthcare career opportunities.

Individuals selected to participate in the Program meet all of the Hospital's Program requirements.

THE HOSPITAL IS REQUESTING YOUR CONSENT TO PERMIT THIS OBSERVER, IDENTIFIED BELOW, TO SPEND SOME TIME WITH YOU DURING YOUR HOSPITALIZATION.

Both the individual identified below and his/her parent (when applicable) have signed a statement stating that they understand that the individual is to maintain in strict confidence all information and data relating to the hospital's patients, and that the student is not to disclose such information to any third party, including his/her family and friends, under any circumstances.

The consent applies only for the dates set forth below.

I understand that the individual who is assigned to me is:
Name: ________________________________School: __________________________________
Home Address: _________________________ City:_____________________________________
Dates student will be observing: ____

I am not currently under the influence of any medication or sedation that would affect my mental ability to understand what I am reading or consenting to and I am freely making the decision whether or not to participate in the Program.

I understand that I have the right to refuse a participant of the Observation Program from observing me, and I can either say that I do not want an observer or not sign this Consent. Not signing this Consent is the same as a refusal and the hospital will honor my wishes. I understand that having an observer, or not having an observer, will not affect my care in any way at this hospital.

I CONSENT TO HAVING AN OBSERVER:

(Circle One) YES NO

Signed: _____________________________________ Date: ____________ Time: ___________

Print Patient Name: ___________________________ Relationship to Patient: _______________

Witness: ____________________________________ Date: ____________ Time:____________