OBSERVERSHIP APPLICATION & INSTRUCTIONS

As requested attached is the observership application and policy. Please review the policy prior to completing the application. You will need to submit the following information along with the completed application. All application submitted with incomplete forms and/or omission of required documents will be returned to you.

All applicants must submit the following:
1. Completed Forms A-E
2. Current copy of CV/Resume
3. Current PPD
4. Proof of Immunization
5. Grady Orientation Documentation (instructions included)

Please see table below for the listing required signatures

<table>
<thead>
<tr>
<th>Form</th>
<th>Applicant</th>
<th>Supervising Provider (s)</th>
<th>Witness</th>
<th>Clinical Manager</th>
<th>Parent/Guardian</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>X</td>
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<td></td>
<td>X</td>
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</tbody>
</table>

Applications must be submitted to Medical Staff Services at least 30 days prior to your requested start date.

Questions: Contact Medical Staff Services at 404-616-4262 or 4265
Fax: 404-616-3066
Email: rjennings@gmail.com
Form A  
Request Form

**DIRECTIONS:**  
- Please print legibly the requested information below and on the attached forms for each observer.  
- Complete the following forms A - D and return them to Medical Staff Services at 80 Jesse Hill Jr. Drive, box 88, Atlanta, GA 30303 or fax to 404-616-3066  
- If you have any questions, please call 404-616-4262 or 4265

<table>
<thead>
<tr>
<th>Name of Observer</th>
<th>Date of Birth</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Address</td>
<td>Name of School/College</td>
<td></td>
</tr>
<tr>
<td>Home</td>
<td>Cell</td>
<td>Email Address</td>
</tr>
<tr>
<td>Clinic/Area to Observe</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Time Frame:**  (30-day limit) Include Start Date, End Date, Hours p/day, Certain Day(s) of week.

**Reason for Observing:**

<table>
<thead>
<tr>
<th><strong>Attending Physician - Providing Supervision</strong></th>
<th>Office #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Print Name:</td>
<td>Pager #</td>
</tr>
<tr>
<td>Signature:</td>
<td>Date:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Resident/Fellow - Providing Supervision</strong></th>
<th>Office #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Print Name:</td>
<td>Pager #</td>
</tr>
<tr>
<td>Signature:</td>
<td>Date:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Clinical Manager - Providing Supervision</strong></th>
<th>Office #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Print Name:</td>
<td>Pager #</td>
</tr>
<tr>
<td>Signature:</td>
<td>Date:</td>
</tr>
</tbody>
</table>

If Observer Is Under Age 18, Please Provide Parent/Guardian Signature:

(Print) Parent/Guardian Name ____________________________ Signature ____________________________ Date ____________

<table>
<thead>
<tr>
<th>Home</th>
<th>Office</th>
<th>Cell</th>
</tr>
</thead>
</table>
Form B
OBSERVERSHIP

Release and Waiver of Liability

I, ________________________________ , wish to observe the activities of the
________________________________________ clinical service at Grady Health Systems from
____________________________ to ___________________________ in furtherance of my personal,
educational goals.

I understand that I will not be allowed to perform any clinical activities or other work, to include the
touching of any patient, documenting on any medical record, and advising or care providers or patients.
I further understand that I will be under the supervision of attending physician
________________________________________ and house staff physician
________________________________________.

I understand I am not to be in any patient care area without one of them being present with me.
I understand that if I breach this agreement, it will result in immediate termination of my observership.
I understand that even though I will only be observing activities in _______________________ clinical
services 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. I am aware of these risks
and voluntarily assume these risks.

For and in consideration of Grady Health Systems allowing me to observe the activities of the
________________________________________ clinical services to further my educational goals. I
hereby release and forever discharge Grady Health Systems and it’s officers, 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 and unknown, 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 I voluntarily choose to participate in the activities described
herein. I hereby certify that I am at least 18 years of age, I am legally competent, and I am signing this
document with full knowledge of its significance.

___________________________________________                ______________________
Observer                                                                 Date

___________________________________________                ______________________
Witness                                                                  Date
Form C
Supervision Agreement of Observership

We, the undersigned, agree to be responsible for supervising __________________________ while he/she observes the activities of the ___________________________clinical services during the period of ___________________________ to ___________________________. We acknowledge that we have Observer ___________________________ to be under our supervision and that he/she is not to be present in any patient care area without one of us being with him/her. We agree to ensure that Observer ___________________________ shall engage in observation activities only and shall not participate in any patient care activities at Grady Health Systems during ___________________________ to ___________________________, which includes touching patients, writing on the medical record, and advising other care providers or patients.

___________________________________________  _________________________
Signature of Attending Physician  Date

___________________________________________  _________________________
Signature of House staff  Date

___________________________________________  _________________________
Witness  Date
Form D
Confidentiality and Non-Disclosure Statement

I, ____________________________, the observer visiting the Grady Health System, am aware of the Hospital’s Regulations and Policies that are issued under the Health Insurance Portability and Accountability Act of 1996 (also known as the HIPAA Privacy Rule).

- I understand that all patient information, including medical records, other medical information, billing and financial data, is confidential.
- I agree to keep all patient information confidential.
- I agree to comply with all Hospital Privacy Policies and Procedures including those implementing the HIPAA Privacy Rule.
- I understand that if I violate patient confidentiality by using or disclosing patient information improperly, I may be subject to disciplinary action including having my observership immediately terminated.
- I understand that if I have any questions or concerns about the Privacy Rule and/or the proper use or disclosure of patient information, I shall ask my Supervisor/Sponsor, the Hospital Privacy Officer, or the Hospital Compliance Officer.
- I understand and agree that the Hospital Privacy Policies and Procedures will apply to all patient information even after my observership has been completed.

**OBSERVER**

Printed Name: ____________________________ Date: ______________
Signature: ____________________________

**SUPERVISOR/SPONSOR**

Printed Name: ____________________________ Date: ______________
Signature: ____________________________
Department/Service__________________________
MEMO OF APPROVAL

To: Senior Vice President, Medical Affairs, Grady Health Systems

From: ________________________________

Subject: Request for Approval of Observership of ________________________________

Date: ______________

I am requesting the approval of an observership for ________________________________, which will be under the supervision of ________________________________ during the period of ______________ to ______________.

I understand that an observership allows an educational process to occur in the clinical setting; however, it does not allow the observer to participate in activities, which involve the touching of patients, writing on the medical record, writing orders for patients, and/or answering questions posed by patients or other care-providing staff regarding the treatment of patients.

Thank you for your attention to this request.

☐ Approved ☐ Denied

_________________________________________ ________________________________
Chief of Service Date

Section above must be completed prior to submission for approval.

_________________________________________ ________________________________
Director, Medical Staff Services Date

_________________________________________ ________________________________
Senior Vice President, Medical Affairs Date