Observer Application and Orientation Process

• Complete the Observer Application Packet:

  ✓ ALL observers must complete the non-employee education to rotate at Covenant Health. Click on the following link or copy/paste the link into your web browser.  http://bit.ly/2ouGvDU  Print/sign the Confidentiality and Release of Information form at the end of this training and return with the packet.

  ✓ Observer Data Sheet

  ✓ Signed Observer Guidelines

  ✓ Documentation of current-year influenza immunization.

  ✓ Current Professional Picture (JPG format) for your Covenant Badge

  ✓ Read and sign the Confidentiality Statement.

  ✓ If you are under the age of 18 please attach a letter of recommendation.

NOTE: Please submit your completed application packet by email to emily.perez@stjoe.org or by fax to 806-723-6020.

Rev. 04/2017
You must be 18 years of age or older and must be enrolled in high school or currently attending college.

Submit completed application and all supplemental documents to Medical Staff Services by email to Emily.perez@stjoe.org or fax to 806-723-6020.

Allow two weeks for processing prior to start of Observation. You may not begin your observation without an Observer badge and Orientation.

I am requesting Observation privileges as a (select one):

☐ Nurse (RN/BSN)  ☐ Other ____________

Full Name: ________________________________

First       Middle       Last

Date of Birth: ____________________________

Month      Day       Year

☐ Male  ☐ Female

Home Address: ________________________________

Cell Phone: ________________________________ Email Address: ________________________________

Current Education and School Supervisor Contact:

Name of School: ________________________________

School Address: ________________________________

School Contact: ________________________________ Phone: ________________________________

Contact email: ________________________________

Where will your Observation take place?  ☐ CMC  ☐ CCH  ☐ CMG Clinic  ☐ Non-CMG Clinic

Are you currently employed by Covenant Health?  ☐ Yes  ☐ No  Which campus? ________________________________

Rev. 04/2017
Supervising Nurse Agreement

I agree that the Observer’s presence with me shall be for the purpose of observation only, and that he/she may not perform any procedures, either in assistance with me or individually. Observer agrees that he/she shall respect the wishes of any patient who objects to his/her presence and that he/she shall abide by the policies and procedures of Covenant Health (Covenant Medical Center/Covenant Children’s Hospital and/or Covenant Specialty Hospital), and comply with the provisions of the Health Insurance Portability and Accountability Act.

I agree that I shall be responsible for all of the Observer’s acts and omissions while he/she is with me at Covenant.

1. [Signature]
   Printed Name: [Julie Bell]
   Observer will shadow with me at: ___ CMC ___ CCH ___ CMG Clinic ___ Cath Lab/OR ___ Other:__________
   Dates of Rotation

2. [Signature]
   Printed Name: [Karen Rambo]
   Observer will shadow with me at: ___ CMC ___ CCH ___ CMG Clinic ___ Cath Lab/OR ___ Other:__________
   Dates of Rotation

4. [Signature]
   Printed Name: [Julia Scott]
   Observer will shadow with me at: ___ CMC ___ CCH ___ CMG Clinic ___ Cath Lab/OR ___ Other:__________
   Dates of Rotation

5. [Signature]
   Printed Name: [Alicia Anger MSN, RN]
   Observer will shadow with me at: ___ CMC ___ CCH ___ CMG Clinic ___ Cath Lab/OR ___ Other:__________
   Dates of Rotation

(Make copies of this page as needed for additional Supervising Nurses)
Supervising Nurse Agreement

I agree that the Observer’s presence with me shall be for the purpose of observation only, and that he/she may not perform any procedures, either in assistance with me or individually. Observer agrees that he/she shall respect the wishes of any patient who objects to his/her presence and that he/she shall abide by the policies and procedures of Covenant Health (Covenant Medical Center/Covenant Children’s Hospital and/or Covenant Specialty Hospital), and comply with the provisions of the Health Insurance Portability and Accountability Act.

I agree that I shall be responsible for all of the Observer’s acts and omissions while he/she is with me at Covenant.

1.)

Signature

____________________________

Dated Name

SUSAN S AYRAI

Observer will shadow with me at: ___ CMC ___ CCH ___ CMG Clinic ___ Cath Lab/OR ___ Other:_________

2.)

Signature

____________________________

Dated Name

TAMMY JONES

Observer will shadow with me at: ___ CMC ___ CCH ___ CMG Clinic ___ Cath Lab/OR ___ Other:_________

4.)

Signature

____________________________

Dated Name

Observer will shadow with me at: ___ CMC ___ CCH ___ CMG Clinic ___ Cath Lab/OR ___ Other:_________

5.)

Signature

____________________________

Dated Name

Observer will shadow with me at: ___ CMC ___ CCH ___ CMG Clinic ___ Cath Lab/OR ___ Other:_________

(Make copies of this page as needed for additional Supervising Nurses)
Supervising Nurse Agreement

I agree that the Observer’s presence with me shall be for the purpose of observation only, and that he/she may not perform any procedures, either in assistance with me or individually. Observer agrees that he/she shall respect the wishes of any patient who objects to his/her presence and that he/she shall abide by the policies and procedures of Covenant Health (Covenant Medical Center/Covenant Children’s Hospital and/or Covenant Specialty Hospital), and comply with the provisions of the Health Insurance Portability and Accountability Act.

I agree that I shall be responsible for all of the Observer’s acts and omissions while he/she is with me at Covenant.

1.) ___________________________  Dates of Rotation

Signature

Printed Name

Observer will shadow with me at:  ____ CMC  ____ CCH  ____ CMG Clinic  ____ Cath Lab/OR  ____ Other:___________

2.) ___________________________  Dates of Rotation

Signature

Printed Name

Observer will shadow with me at:  ____ CMC  ____ CCH  ____ CMG Clinic  ____ Cath Lab/OR  ____ Other:___________

4.) ___________________________  Dates of Rotation

Signature

Printed Name

Observer will shadow with me at:  ____ CMC  ____ CCH  ____ CMG Clinic  ____ Cath Lab/OR  ____ Other:___________

5.) ___________________________  Dates of Rotation

Signature

Printed Name

Observer will shadow with me at:  ____ CMC  ____ CCH  ____ CMG Clinic  ____ Cath Lab/OR  ____ Other:___________

(Make copies of this page as needed for additional Supervising Nurses)
GUIDELINES FOR MEDICAL STAFF OBSERVERS AT COVENANT HEALTH

1. Permission to observe a Medical Staff member of Covenant Health (Covenant Medical Center/Covenant Medical Center-Lakeside, Covenant Children’s Hospital and/or Covenant Specialty Hospital) is given as a public service to further interest in healthcare careers.

2. Observers may not provide any activities related to provision of medical care to patients including, but not limited to: diagnosing diseases, administering medications, performing surgical procedures, suturing, providing medical advice or any other tasks generally reserved for the trained health professional.

3. Photography of any kind is strictly forbidden in any patient care area or other location that could violate patient confidentiality.

4. Observers must remain with the Supervising Physician at all times while in patient care areas of the hospitals.

5. Patients have the right to refuse to have Observers present for any examination, procedure, test or surgery.

6. All Observers must wear an Observer badge above the waist in a visible manner at all times while on Covenant Health premises.

7. Observers must dress in attire consistent with Covenant Health policies and procedures.

8. Observers must maintain strict confidentiality and privacy in accordance with hospital policies and procedures and the Health Insurance Portability and Accountability Act (HIPAA).

I have read and agree to abide by the Guidelines for Observers at Covenant Health. To the best of my knowledge, all information I have supplied is accurate and complete. I hereby release and hold harmless Covenant Health and all of their related and/or affiliated entities along with their respective directors, officers, representatives, agents, licensees, and/or employees, of any and all liability, damages, causes of action, suits, claims or judgments relating to my participation at Covenant. This release and hold harmless shall be binding upon me and my heirs, executors, administrators and assigns.

__________________________________________________________________________  _______________________
Observer Signature                                                      Date
CONFIDENTIALITY STATEMENT
(For Students/Volunteers)

As a student or volunteer performing duties at Covenant Health System (CHS), you will have access to the protected health information (PHI) of patients. Federal and State laws, including HIPAA and other policies and procedures created internally, protect the privacy and security of this PHI, including the fact that an individual was a patient at CHS. It is illegal for you to use or disclose PHI outside the scope of your duties at CHS. This includes oral, written, or electronic uses and disclosures. Below are some guidelines that you must be familiar with regarding the use of a patient’s PHI.

1. You may use PHI as necessary to carry out your duties as a student/volunteer;
2. You may share PHI with other health care providers within CHS for the direct treatment of the patient;
3. You may NOT photocopy or otherwise permit PHI to be duplicated in any way;
4. You may NOT photograph patients;
5. You must access only the minimum amount of PHI necessary to care for a patient or to carry out an assignment;
6. You may NOT record PHI (such as patient names, diagnoses, dates of birth, addresses, phone numbers, Social Security numbers, etc.) on any assignments you may need to turn in to your instructor, reports you may need to turn in to your program, or forms you may need to take with you;
7. You may only access the PHI of patients for whom you are caring/volunteering when there is a need for the PHI;
8. You must be aware of your surroundings when discussing PHI. As an example, it is inappropriate to discuss PHI in elevators, bathrooms, the cafeteria, and any other place for which your discussion may be overheard;
9. When disposing of any documents with PHI, do NOT place them in the trash can. Instead, the documents should be placed in the proper containers marked for shredding or another disposal container as set forth by policy and procedures for your specific department;
10. If you have questions about the use or disclosure of PHI, contact Natalie Ramello (806.725.0085).

Please read, sign, and date this acknowledgement. Return it Medical Staff Services where it will be filed with your application.

Acknowledgment

I have read and I understand the information in this document. I realize that there are penalties for which I may be subject, including criminal, for the unauthorized use and disclosure of PHI. I agree to abide by the guidelines described above when performing my duties at Covenant Health System.

I understand and agree that in the performance of my duties within Covenant Medical Center/Covenant-Women’s and Children’s and Covenant Children’s Hospital I may become aware of information that could be considered confidential. It is my responsibility to protect the privacy of patients, employees and the hospital. I understand that my failure to comply may result in disciplinary action from my physician supervisor.

Name (Print): ___________________________ Date: ___________________________
Signature: _____________________________

Rev. 01/17
Observer Orientation

Student: ___________________________  Date: ___________________________

Supervising Department: ___________________________

Dates of Rotation: ___________________________

1. Parking
   - Park 4th/5th floor of East Parking Garage (enter on north side); Sky bridge on 3rd floor
   - Emergencies/Escorts to cars 725-0707
   - Put everything in your trunk
   - Park in the back of the lot – W&C and Plaza
   - Street – watch for signs so you don’t get a ticket

2. Professionalism
   - Appropriate dress – clean, pressed, badge present at all times – Jeans will not be allowed when shadowing
   - Acknowledge, Introduce, Duration, Explanation, Thank (AIDET)
     - Listening Carefully
   - Get Clear Instructions of expectations from your supervising nurse
   - Be on Time! If you are more than 10 minutes late you will need to be rescheduled.
   - WASH HANDS

3. Patient/Observer Interaction
   - Badge must be visible at all times.
     - If an Emergency Code is called, hospital personnel will direct you on protocols. Stay with the Attending.
   - Must be with your supervising nurse at all times when rounding.
   - Must follow the wishes of the patient. If they do not want you in the room, politely step out of the room.
   - Speak only when spoken to other than pleasantries. Ask your supervising Nurse if s/he would like for you to introduce yourself.
   - Patient Privacy and Confidentiality must be maintained at all times. Do not discuss your Observation Experience, including Social Media.
   - You may NEVER provide direct hands-on patient care at any time.

4. At the completion of your Orientation, return the badge to Emily Perez, Recruiter.

5. If you decide to extend your time frame, you will need to contact Emily Perez to pick up your application, and get the physician’s signature for the additional time of your observation.

6. If you need anything during your rotation, contact Emily Perez, 725-0612.