Grady

Form A

Request Form

Print/Type legibly the requested information below **(Submit only One Form per Observer)**. If you have any questions, please call (404) 616-4262. Complete Forms A through D, and return them to Grady Medical Staff Services.

Name of Observer	Date of Birth	Age

Home Address	Name of School/College

Home Phone Number	Mobile Phone Number	E-mail Address *Your Approval Notice will be sent to this address.*

Observership Category & Timeframe to be Requested

*Observership **Category I** (Undergraduate & Graduate Pre-Medical Students) maximum time frame allowed is thirty (30) days. Timeframes requested greater than thirty (30) calendar days will be denied. Please indicate start date (10/07/XXXX) and end date (11/07/XXXX) below. Observership **Categories II, III, IV, V** (please see Observership Policy for criteria definitions) maximum time frame allowed is five (05) days. Timeframes greater than five (05) calendar days will be denied. Please indicate start date (10/07/XXXX) and end date (10/12/XXXX) below.*

Observership Category Requested *(Proof of Category Requirements will be verified)*	Start Date (XX/XX/XXX)	End Date (XX/XX/XXX)
☑ I ☐ II ☐ III ☐ IV ☐ V	**09/20/2018**	**11/15/2018**

Clinic/Area to Observe	Reason for Observing
MSM Department of Surgery ROEO	***ROEO Youth Medical Mentoring Program***

Attending Physician Providing Supervision

Print Name: **Dr. Omar K. Danner** **Office #:** **(404) 616-1415**
Pager #:
Signature: **Date:**

Resident/Fellow Providing Supervision

Print Name: **Office #:**
Pager #:
Signature: **Date:**

Clinical Manager Providing Supervision

Print Name: **Office #:**
Pager #:
Signature: **Date:**

Parent/Guardian Approval *(If observer is under the age of 18)*

Print Name: **Home #**
Office#:
Cell#:
Signature: **Date:**

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Form B

Observership Release & Waiver of Liability

I, _____ wish to observe the activities of the

MSM Department of Surgery ROEO clinical service at Grady Health System from

09/20/2018 *to* **11/15/2018** 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 in any medical record, and advising any care providers or patients. I further understand that I will be under the supervision of attending physician.

Dr. Omar K. Danner and house staff physician

_____ or GHS employee

_____ ("Supervisor").

I understand I am not to be in any patient care area without one of my Supervisors being present with me. I understand that if I fail to comply with this requirement, it will result in immediate termination of my observership.

I understand that even though I will only be observing activities in **MSM Department of Surgery ROEO** 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 System allowing me to observe the activities of the

MSM Department of Surgery ROEO clinical services to further my educational goals.

I hereby release and forever discharge Grady Health System and its 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 observership 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's Signature **Date**

_____ _____

Witness' Signature **Date**

Form C

Supervision Agreement of Observership

We, the undersigned, agree to be responsible for supervising _____

while he/she observers the activities of the **MSM Department of Surgery ROEO** clinical services during the period of **09/20/2018** *to* **11/15/2018**. We acknowledge that Observer _____ is 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 System during his/her observership, which includes touching patients, writing in the medical record, and advising other care providers or patients.

Attending Physician Signature	**Date**
House Staff Signature	**Date**
GHS Employee Signature	**Date**
GHS Employee's Department Director Signature	**Date**
Witness Signature	**Date**

Form D

Confidentiality & Non-Disclosure Statement

I, _____ an Observer visiting Grady Health System, am aware of the Grady Health System'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

_____ _____
Signature **Date**

SUPERVISOR/SPONSOR

MSM Department of Surgery ROEO
_____
Department/Service

Dr. Omar K. Danner
_____
Printed Name

_____ _____
Signature **Date**

Grady

Form E

Memorandum of Approval

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

From: **Dr. Omar K. Danner**

Observer: _____

Date: _____

I am requesting the approval of an observership for _____ which will be

Sponsored by **MSM Surgery Department** and under the supervision of **Dr. Omar K. Danner**

during the period of **09/20/2018** *to* **11/15/2018**.

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 in the medical record, writing orders for patients, and/or answering questions posed by patients or other healthcare providers regarding the treatment of patients.

❑ Approved ❑ Denied

_____ _____

Chief of Service Signature **Date**

_____ _____

Director, Medical Staff Services Signature **Date**

_____ _____

EVP Sr. VP, Medical Affairs/CMO Signature **Date**

Clear Form