HEALTHCARE CAREER OBSERVER CHECKLIST

QUALIFICATIONS

☐ Must be at least:
  o 15 years of age prior to being permitted to observe in a non-patient care area;
  o 16 years of age and at least the educational level of a junior in high school prior to being permitted to observe
    in a patient care area;
  o 17 years of age and at least the educational level of a senior in high school prior to being permitted into an
    OR.

☐ Must be sponsored by a UH RMC medical staff or workforce member.
  o Observers must identify their own sponsor; if an Observer does not have a sponsor identified, the Volunteer
    Services Department may provide department phone numbers where the Observer wishes to observe.

APPLICATION PROCESS

☐ All applicants must have the following completed and returned to the UH RMC Volunteer Services Department before
  being accepted into the Healthcare Career Observation Program:

  o Observation Application Form* (Attachment A)
  o Sponsor Form (Attachment B) (completed and returned to Volunteer Services Department by UH RMC
    staff member)
  o Consent for Participation/Confidentiality Form* (Attachment C)
  o Observation Orientation Quiz (Attachment D) (be sure to complete the Orientation for the UH entity at
    which you will be observing)
  o Patient Consent (Attachment E)
  o Copy of current health insurance card
  o Copy of current photo ID (e.g. driver’s license, state ID, student ID)
  o Proof of negative TB test performed within the past year, if observing at UH for more than one day.

* (if under 18 years of age, parent/legal guardian must sign)

FIRST DAY

☐ Arrange to have sponsor meet you in the Volunteer Services Department or know the area where you are to meet your
  sponsor.
☐ Obtain ID badge from Volunteer Services Department.
☐ Begin tracking your hours on your Observation Log Sheet. Be sure to do so every day you observe.

LAST DAY

☐ Return ID badge and completed Observation Log Sheet to Volunteer Services Department.

DRESS CODE

Dress code is business casual – if not dressed appropriately you will be sent home.

☐ You must wear your ID badge above your waist while on the premises.
☐ Jeans and capris are not acceptable; slacks and khakis are appropriate.
☐ Shorts, tank tops, halter tops, sleeveless tops and tops which expose your midriff are not permitted.
☐ Wear clean, comfortable shoes; tennis shoes are allowed but they must be tied. Open-toed shoes/sandals are not
  permitted.
☐ Do not wear excessive or dangling jewelry, jewelry or in-face/tongue piercings. Visible tattoos must be covered. Do not
  wear hats.
☐ Strong perfume or cologne is not permitted; gum chewing is not permitted.
HEALTHCARE CAREER OBSERVATION

SPONSOR RESPONSIBILITIES

☐ When accepting an Observer in your area, please complete and submit an Observation Sponsor Form (Policy GM-38, Attachment B) to the UH RMC Volunteer Services Department.

☐ Ensure the Observer has supervision AT ALL TIMES and give advance notice to the appropriate departmental workforce members who will have contact with and/or responsibility for the Observer.

☐ Assure any patient to be observed has signed the Patient Consent Form (Policy GM-38, Attachment E). The patient being observed must sign the Patient Consent Form before receiving sedation and be otherwise competent to give consent. Assure the Patient Consent Form becomes part of the patient’s chart.

   NOTE: If the patient refuses to give consent, the Observer is not permitted to observe the patient.

☐ Provide Observer with guidance as to appropriate attire. Observers may not wear open-toed shoes, tank tops, jeans, exposed midriffs, heavy perfume or cologne, dangling jewelry, or jewelry in tongue or in-face piercings. Observers who are dressed inappropriately will be sent home.

☐ Arrange with your Observer the date and time to begin the observation and communicate this to the Volunteer Services Department. Obtain ID badge from Volunteer Services Department.

☐ Provide orientation to the hospital’s and department’s safety standards and infection control procedures. Please note, any Observer at UH for more than one day is required to show proof of a negative TB test performed within the past year. If necessary, the Volunteer Services Department will assist the Observer with getting tests completed.

☐ Complete Observer progress reports/final evaluations for school as requested.

☐ Ensure the Observer ID badge and completed Observation Log Sheet are returned to the Volunteer Services Department after the last day of observation.

Please review UH Policy GM-38 “Healthcare Career Observation Program” for additional information. Information regarding Observers in the OR is under items 5.6 and 5.7.
# ATTACHMENT A

## OBSERVATION APPLICATION FORM

### PERSONAL INFORMATION

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### PROJECT INFORMATION

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<th>Start date</th>
<th>End date</th>
<th># of hours requested</th>
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Please describe why you are interested in doing an observation in this area:

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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.

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**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.

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<th>Printed Name</th>
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Please mail or fax completed application to appropriate entity (addresses of entities are available at www.uhhospitals.org)
### Sponsor Contact Information

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<th>Department:</th>
<th>Phone:</th>
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<tr>
<td>Supervisor/Contact Person:</td>
<td>Phone:</td>
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<tr>
<td>Person Student Observer Reports to:</td>
<td>Phone:</td>
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<tr>
<td>Location:</td>
<td>Room:</td>
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### Observer Information

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<td>Address:</td>
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<td>City:</td>
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<td>Relationship to sponsor:</td>
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*Please note the minimum age for student observers in a patient care area is 16 and a junior in high school. Operating room and labor & delivery require a higher minimum age of 17 and a senior in high school.*

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### Observation Description

<table>
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<tr>
<th>Start Date:</th>
<th>End Date:</th>
<th># of Hours:</th>
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Description of what student will observe and/or activities:

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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 Volunteer Services in contacting the above student and will ensure the student completes all procedures and paperwork prior to beginning the observation.

<table>
<thead>
<tr>
<th>Printed Name:</th>
<th>Signature:</th>
<th>Date:</th>
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Please mail or fax completed application to appropriate entity (addresses of entities are available at [www.uhhospitals.org](http://www.uhhospitals.org))
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 its 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
**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:**

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<tr>
<th>Print Name</th>
<th>Signature of Observer</th>
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<td>Street Address</td>
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**Name of School**

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

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<th>Print Name</th>
<th>Signature of Parent or Legal Guardian</th>
<th>Date</th>
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<tr>
<td>Street Address</td>
<td>City/State/Zip</td>
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OBSERVATION ORIENTATION

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
- Access 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 hygiene is the single most effective method of preventing transmission of infections. Use a dime-sized amount of alcohol-based hand sanitizer offered in all patient care areas when hands are not visibly soiled, make sure to cover all surfaces of your hands, and allowing to dry. Wash hands with soap and water when they are visibly soiled, alcohol based sanitizer builds up on skin, or when you are unable to use sanitizer because of the patients’ condition. Either process should take no less than 15 seconds to complete. Be sure to 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, Elevators.
The term CODE RED means fire. For fire or medical emergency, call 77.
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 77
- 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/PROTECTIVE SERVICES

Protective Services 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 6282.
Name _________________________________________________

Date _________________________

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 with an emergency?
   (A) 411
   (B) 77
   (C) 6134
   (D) 911

3. At UH RMC, 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. T    F    The single most important thing to do to reduce the risk of infection is hand hygiene.

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. T    F    Patient information is confidential and should not be shared. What you see here and hear here stays here when you leave here.
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: __________
HEALTHCARE CAREER OBSERVATION LOG SHEET

Please keep track of all hours spent observing and return completed Log Sheet to the Volunteer Services Department on your last day.

Observer’s Name: ________________________________

Sponsor’s Name: ________________________________

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<th>Department</th>
<th>Date</th>
<th>Time In</th>
<th>Time Out</th>
<th>Hours Worked</th>
<th>Sponsor Initials</th>
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