**Department of Medical Education**
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# CLINICAL OBSERVER
# CONSENT AND RELEASE

Observing clinical activities at Southern Ohio Medical Center (SOMC) is a special opportunity that is infrequently permitted. When observers are permitted it is essential that they understand the expectations placed upon them.

Providing quality health care services requires us to carefully credential every health care provider that performs hands-on patient care. The health care providers that come into contact with our patients are carefully selected and monitored. ***Under no circumstances may observers participate in any procedure they are observing.*** The observer's role is limited strictly to observing the clinical activities of SOMC personnel.

Observers will be provided with a brief orientation and will be expected to follow any instructions given by hospital personnel. All patient information must remain confidential. Observers may not review patient charts nor may they share patient information with anyone outside of the hospital. Although it is unlikely, observers must be aware that they may risk exposure to infectious disease if they come into contact with blood or other body fluids. Observers will be expected to take precautions to prevent exposure such as wearing appropriate protective attire when instructed to do so.

*Observers under the age of 18 must receive permission of their parent or guardian.*

I, _____, have read the above and agree to comply with its requirements. I understand that as an observer I may not participate in clinical activities. As an observer I must be accompanied at all times by the SOMC personnel I am observing. I agree to confidentially maintain any patient information that I may acquire as an observer. I further agree to follow any instructions given to me by SOMC personnel while I am observing. I understand that I may be asked to leave a patient room or other area of the facility at any time by the personnel I am observing.

My participation as an observer is at my own risk. If I should become ill or be injured while observing or otherwise require medical attention, I will be attended to only as circumstances permit. I will be financially responsible for any medical treatment provided to me should I become ill or injured while observing. I agree to release Southern Ohio Medical Center from any and all responsibility or legal liability for any personal injuries or other claims that may arise from my participation as an observer.

_____
Name of program or school sponsoring observation activity

_____ Date: _____
Signature of Observer

_____
Signature of Parent or Guardian
if Observer is under 18

Southern Ohio Medical Center

Very Good things are happening here

**Personal**

Student Name: _____ Phone: _____
Address: _____
Email: _____
16-17 years of age: Yes / No Parent Guardian Name: _____
Have you ever been an SOMC employee? Yes / No
Name of High School: _____ Year of Graduation: _____
Name of Undergrad School: _____ Year of Graduation: _____
Name of Medical School: _____ Year of Graduation: _____
Desired Residency: _____

**Request**

Dept. Requesting_____ Provider Requesting_____
# of Hours_____ Start Date_____ End Date_____
**Provider Signature**_____ ☐ **Approved** ☐ **Not Approved**

Dept. Requesting_____ Provider Requesting_____
# of Hours_____ Start Date_____ End Date_____
**Provider Signature**_____ ☐ **Approved** ☐ **Not Approved**

Dept. Requesting_____ Provider Requesting_____
# of Hours_____ Start Date_____ End Date_____
**Provider Signature**_____ ☐ **Approved** ☐ **Not Approved**

**Requirements Checklist**

_____ Complete Shadowing Consent form
_____ Contact Provider for approval and have them sign form
_____ 16-17 years old – Parent/Guardian Signature
_____ 2 Step TB test, Flu Vaccination, and COVID Vaccination
_____ Go to Medical Education to sign acknowledgment of guidelines
_____ Obtain Observer badge and return to Medical Education on your last day

## Understanding and Release Statement - Southern Ohio Medical Center

I understand that I am responsible for any illness or injury that I may incur while participating in the Shadow Program and accept responsibility for any and all expenses that may result from such illness or injury. I hereby release Southern Ohio Medical Center, employees, officers, members of the Board of Directors and members of the medical and clinical staff from any responsibility related to any such illness or injury. I understand that I will not receive wages and am ineligible for associated unemployment compensation or worker's compensation claims.

_____ _____
Applicant Date

_____ _____
Parent / Guardian Date

## Confidentiality Statement

I understand and agree that I must hold on strictest confidence any observation I may make or hear regarding any patient, or patient's family or staff.

_____ _____
Applicant Date