OBSERVATION ONLY AGREEMENT

Peninsula Regional Medical Center

✓ Student to complete
★ Physician to complete

OBSERVER: ✓ _____ DATE(S) OF OBSERVATION: ✓ _____

PURPOSE OF EVALUATION: ✓ _____

✓ AREA(S) OF OBSERVATION: **Patient Care areas including these specific areas (check all that apply)**

☐ Surgical Services ☐ Emergency Services Dept. ☐ Pediatrics
☐ Mother / Baby ☐ Labor and Delivery ☐ NICU (Special Care Nursery)
☐ Other: _____

REFERRING AGENCY / SCHOOL / HOSPITAL: ✓ _____

PHYSICIAN / PA / NP / CRNA / CNM PROVIDING SUPERVISION: ✓ _____

This completed form is to be submitted to the Medical Staff Services office for processing at least two business days prior to the scheduled observation.

1. The Observer shall participate in an "observation only" program at Peninsula Regional Medical Center in the area(s) specified in this agreement.
2. The Observer can only "observe" the care that is provided by the Physician/Physician group, Physician Assistant, Nurse Practitioner, Certified Nurse Anesthetist or Certified Nurse-Midwife that participates in the observation status.
3. The Observer shall not participate in the delivery of health care services in any way, but shall continue his/her activities solely to observations.
4. During the term of this Agreement, the individual responsible for supervision and the Referring Agency, if applicable, shall be responsible for all actions of the Observer.
5. Observer agrees to abide by all the rules and regulations of Peninsula Regional Medical Center during the course of this Agreement, including without limitation, protection of the privacy of Peninsula Regional Medical Center's patients. **Confidentiality must be maintained at all times, both on and off the Peninsula Regional Medical Center campus.**
6. If the Observer is under the age of 18, a parent or guardian must read and sign this form attesting to their understanding of the above guidelines.
7. Observer shall meet the minimum requirement of being a senior in high school.
8. Observer will attach a copy of their Driver's License and Student ID (if applicable)

✓ **OBSERVER**

Signature: _____ Date: _____

Address: _____

Telephone: _____ Email address: _____

PARENT OR GUARDIAN (if observer is under the age of 18):

Signature: _____ Date: _____

Address: _____

Telephone: _____

**** VERIFICATION OF COMPLETION OF SURGICAL SERVICES ORIENTATION PROGRAM:**

Signature: _____ Date: _____

Perioperative Educator: Susan Lynch

★ **PROVIDER RESPONSIBLE FOR SUPERVISION:**

Provider Signature: _____ Date: _____

Supervising Physician Signature: _____ Date: _____

Required when Provider is an APP i.e., Physician Assistant, Nurse Practitioner, Certified Nurse Anesthetist or Certified Nurse-Midwife.