Request to Observe Patient Care **NCH Healthcare System** **28 days or less**

OBSERVER INFORMATION	*Name:* *City, State/Province:* *E-mail address:*	*Street Address:* *Country, if not USA:* *Cell Phone Number:* *Emergency Contact (Name and Cell Phone Number):*
SCHOOL/UNIVERSITY	*Name:* *City, State/Province:*	*Street Address:*
SPONSOR INFORMATION	*Name:* *Office Location (Suite #):*	*Position:* *Phone Number:* *E-mail Address:*

Type of Observer:
- ☐ Physician
- ☐ Medical student considering residency
- ☐ Considering a career in healthcare
- ☐ Other/Description:

Reason for Observation:
- ☐ Student career planning
- ☐ Other/Description:

Procedures/Activities to be Observed:

☐ Surgery/Procedures ☐ Hospital Rounds ☐ Clinic Activities ☐ Labs ☐ Research

Other (describe):

Date(s) Observer will be observing (**not to exceed 28 days/year**):

Single Visit: _____ (M/D/YY)

Multiple Visits – Dates: _____ (M/D/YY)

Sponsor agrees that:

- He/she has reviewed the Observation of Patient Care Policy.
- Observers under 18 years of age are prohibited from observing
- Each Observer has completed the required NCH online training and has signed the *NCH Confidentiality Statement*. (A copy of the signed *Confidentiality Statement* is attached to this request).
- Observer provided documentation of TB testing, flu vaccine, and COVID-19 vaccination.
- Prior to observation, sponsor must obtain each patient's consent to the presence of the Observer(s); that consent shall be recorded in the medical record in accordance with NCH privacy policies.
- **The Observer(s) shall not participate in patient care.**
- Sponsor assumes full responsibility for the actions of the Observer(s) and agrees to ensure that the Observer(s) complies with all NCH policies and procedures and all applicate state and federal laws while observing at NCH.

Signature of Sponsor:	**Date:**

Return completed form with attachments to: DL_Observation@nchmd.org

Signature of GME Representative:	**Date:**

Form retained by GME Department