

## UW Medicine APPLICATION AND AGREEMENT FOR OBSERVATIONAL ACTIVITIES

Please fill out completely. Incomplete forms cannot be processed. Complete yellow highlighted areas

Name:		Degree:		Day Phone:	
Address:				Evening Phone:	
City:		State:		Zip:	
School (if applicable):		Grade level:		Career / Study interest:	
I am 18 years of age or older <input type="checkbox"/> Yes <input type="checkbox"/> No, I am _____ years old					
Current Job Title:				Company Name:	
Address:				Phone Number:	
Have you ever been convicted of a felony? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Have you ever had a license revoked or denied? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<input checked="" type="checkbox"/> I have made specific arrangements with a UW Medicine employee and have been approved for an observational experience. Approved by:					
Name: Susan Astley, Ph.D				Title: Director, FAS DPN Clinic	
Dept/Unit: Center Human Dev. Disabil.				Phone: (206) 598-0555	
Date approved:					
Reason for being in the UW Medicine Area (Please circle one of the following)					
A. I am a medical professional(e.g. physician, ARNP, PA, Nurse, Medic, health professions student) seeking additional experience					
B. I am a medical professional (e.g. physician, ARNP, PA, Nurse, Medic) seeking to observe at the invitation of _____ for the purpose of mutual sharing of clinical, teaching and / or research.					
C. I am employed by a commercial vendor and am participating in the development or conduct of collaborative research with _____:					
D. I am employed by a commercial vendor and am providing specific training to _____ and his / her staff.					
E. Other: Please explain in detail.					
Start Date of Observational Activity:				End Date of Observational Activity:	
<p>I understand the observational activity provided is done as a public service in the interest of medical education.</p> <p>I understand the observational activity provided does not permit photography by the observer.</p> <p>I understand that all information about patients, whether it is medical or personal, is absolutely confidential. I have read and signed the confidential acknowledgement form listed on the back of this page.</p> <p>I understand that as an observer, regardless of background and training, I may not perform any medical procedures. I will not have direct contact with patients, nor have unsupervised access to patients.</p> <p>I agree to the following statements:</p> <ul style="list-style-type: none"> <li>• My required immunizations are current and I have attached my immunization records.</li> <li>• I have not had any exposure to measles, rubella or chickenpox in the last 30 days.</li> <li>• If this observational assignment lasts more than 3 weeks, I will report to the UW Medicine Entity's Employee Health office for a Tuberculosis screening.</li> </ul> <p>I agree to hold harmless the University of Washington and UW Medicine from any present and future liability and/or damages for injuries arising from or growing out of this observational experience.</p>					
Signature of applicant:				Date:	
<u>Parental Permission for Minors (for applicants under 18 years of age)</u> My daughter/son has permission to participate in a UW Medicine observational experience and I authorize UW Medicine to administer a Tuberculosis test as deemed necessary. I understand the above statements and verify the information is accurate and complete.					
Signature of Parent or Guardian:				Date:	

**NON MEDICAL STAFF OBSERVATIONS**

I understand that I will be responsible for this person for the duration of this observational activity.	
Name of UW Medicine employee host:	Date:
Signature:	Work Phone:

**MEDICAL STAFF OBSERVATIONS**

I know this applicant and based on my knowledge of this applicant, his/her training, current competence, and health status as it affects performance, I attest that this person is physically and mentally competent to observe in the UW Medicine Clinics or other UW Medicine areas, and is observing for the purpose of medical education, research or training. I attest that the purpose of this is not solely for the benefit of a commercial vendor. I also attest that I will receive the permission of the patient(s) for this person to observe.

A. The person observing will be in my presence at all times (Please circle one): yes no

B. If no, please explain who will supervise the person observing?

The supervising Physician should introduce the visitor to patients.

Signature:	Date:
Supervising Physician	
Temporary Observation Privileges are Granted:	
Signature:	Date:
Medical Director	

**Confidentiality Acknowledgement Form for Observational Activities**

UW Medicine has a legal and ethical responsibility to safeguard the privacy of all patients and protect the confidentiality of their protected health information (PHI). Strong federal and state laws govern the privacy of our patients and their health information.

When you participate in an observational experience at UW Medicine, you are involved in a unique experience. You will be accompanying a health care professional for a specified period in a health care facility. During this time you will or may be seeing patients with a variety of medical issues and/or you may see and hear confidential information relating to these patients. This relates to information past, present and future.

As a condition of participating in this observational experience, I understand and agree that:

- I must maintain and safeguard the confidentiality of any and all UW Medicine protected health information.
- I will not access, use or disclose protected health information unless specifically approved as part of my observational experience. I will maintain all protected health information in the strictest confidence and will not disclose or allow access to protected health information to others.
- Any access to protected health information may be monitored to assure appropriate compliance with system integrity and UW Medicine policies and procedures.
- If I fail to comply with the above confidentiality guidelines, or if I breach patient confidentiality, this agreement will be terminated and my ability to participate in future activities at UW Medicine may be denied.

Signature of applicant/student:	Date:
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<input checked="" type="checkbox"/> Temporary UW Medicine Entity Badge issued. (Please follow the policies below for entity badge)	
HMC Photo Identification Badges Policy 125.6	
UWMC, please contact the Public Safety Office at 598-4907 or 598-4909 The FAS Clinic will obtain badge	
Signature of applicant/student:	Date:

**Persons involved in observational activities in patient care areas at UW Medicine must complete the UW Medicine Immunization Health History form.**

**Return this completed form to:**  
 Your Department Administration  
**For more information, contact [hipaa@u.washington.edu](mailto:hipaa@u.washington.edu)**  
 (206) 616-5248

UW Medicine  
IMMUNIZATION HEALTH HISTORY FORM

This form must be completed for all individuals who will be accessing patient areas.  
 Harborview Medical Center       University of Washington Medical Center

Please complete **all** non shaded areas

Name \_\_\_\_\_ Social Security Number \_\_\_\_\_  
Last First MI - -

Address \_\_\_\_\_  
Street City State Zip

Phone: ( ) \_\_\_\_\_ Date of Birth / /  
Home Work Ext. or Page #

Are you exposed to blood or body fluids on the job? (circle one) **YES** **NO**

Department Name: \_\_\_\_\_ Box Number \_\_\_\_\_

Job Title: \_\_\_\_\_ Date of Employment / /

Please list any Chronic Disease or Illness \_\_\_\_\_ Allergies \_\_\_\_\_

Comments:

IMMUNIZATION HISTORY <b>PROVIDE DATES</b>							
See reverse side for Immunization Requirements							
DISEASE	HAVE YOU EVER HAD THE DISEASE? Y/N	1st dose	2nd dose	3rd dose	LAST BOOSTER	ANTIBODY	OFFICE USE ONLY
HEPATITIS B						DATE: RESULT:	
MEASLES RUBEOLA OR 10 DAY						DATE: RESULT:	
RUBELLA GERMAN MEASLES OR 3 DAY						DATE: RESULT:	
MUMPS						DATE: RESULT:	
POLIO							
TETANUS DIPHTHERIA							
VARICELLA (CHICKENPOX)						DATE: RESULT:	

TUBERCULOSIS SCREENING					
TB SCREENING	EVER HAVE BCG? YES NO	LAST PPD DATE: RESULT:	CHEST X RAY ONLY IF PPD REACTIVE	DATE: RESULT:	NEXT SCREEN DUE
Employee Signature _____ date _____			Reviewed by _____ date _____		

TODAY'S SCREEN	NEW EMPL SCREEN PPD DATE	CHEST X-RAY DATE	TWO STEP NEEDED (CIRCLE IF APPLIES)
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## DEFINITIONS AND CRITERIA FOR CURRENT IMMUNE STATUS

**MEASLES\*** One of the following must apply

- Positive history of illness diagnosed and documented by a physician **or**
- Positive serology (blood test for antibody) **or**
- Two doses measles containing vaccine, both after 1968 and after age 15 months

**MUMPS\*** One of the following must apply

- Positive history of illness diagnosed and documented by a physician **or**
- Positive serology (blood test for antibody) **or**
- Two doses of Mumps containing vaccine given after 1968 and after age 15 months

**RUBELLA\*** One of the following must apply

- Positive history of illness diagnosed and documented by a physician **or**
- Positive serology (blood test for antibody) **or**
- One dose rubella containing vaccine given after 1968 and after age 15 months

**HEPATITIS A** Vaccine offered for persons at risk for occupational infection and/or who may expose clientele.

- Positive serology (blood test for antibody) **or**
- One dose of Hepatitis A vaccine

**HEPATITIS B \*#** Vaccine offered for persons at risk for occupational infection.

- Positive serology (blood test for antibody) **or**
- Completion of series of three doses of vaccine, administered at 0, 1, and 6 months, or other approved schedule

### **POLIO**

- Completion of primary series of three doses of either IPV (shots) or OPV (by mouth)

### **DIPHTHERIA**

- Completion of the primary series and booster doses every 10 years

### **TETANUS**

- Completion of the primary series and booster doses every 10 years

### **TUBERCULOSIS SCREENING#**

- Tuberculosis screening is required on entry into the University of Washington system. Personnel with prior positive TB skin tests (PPD) must provide written documentation of the skin test reaction size and the results of a subsequent chest x-ray. Personnel with non-reactive TB skin tests shall be retested periodically based on the risk of occupational exposure to tuberculosis. Annual testing is required for low risk occupations, and every 6-month testing is required for persons working with TB patients. Post exposure evaluation is also required for personnel who have had an unprotected exposure to active, infectious tuberculosis cases.

**VARICELLA\* Vaccine** offered for persons at risk for occupational infection and who may expose susceptible clientele.

- History of chickenpox **or**
- Positive serology (blood test for antibody) **or**
- Two doses of Varicella vaccine for antibody negative persons

\*Waiver for immunization may be signed.

#Regulatory requirement for screening: offer of immunization, or have waiver of immunization signed.