PP-04 Attachment D
Rev. 5/30/2012

UW Medicine

CHDD/FASDPN
*immunization/TB record exempt

# Application and Agreement for Observational Activities

Please fill out completely and allow 2 weeks for processing. Incomplete forms will not be processed.

Return to: ☑ Host Department, email: fasdclin@uw.edu; phone: 206-598-9666

☐ Observer

Complete yellow highlighted areas

This form may be scanned and emailed, or for questions, email: [redacted]

fasdclin@uw.edu
FAX: 206-598-7815

| Name: | | Degree: | Day Phone: |
|---|---|---|---|
| Address: | | | Evening Phone: |
| City: | State: | Zip: | Email: |
| School (if applicable): | | Grade level: | Career / Study interest: |

I am 18 years of age or older ☐ Yes ☐ No, I am _____ years old
(Please note that at Valley Medical Center, all individuals must be over 18 years of age to observe)

Have you ever been convicted of a felony? ☐ Yes ☐ No

Have you ever had a license revoked or denied? ☐ Yes ☐ No

☑ I have made specific arrangements with a UW Medicine employee:

| Name: Susan Hemingway PhD | Title: Director, FAS DPN Clinic |
|---|---|
| Dept/Unit: Center on Human Development & Disability | Phone: (206) 598-0555 |

Reason for requesting observational activities: (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.

I am a community professional seeking to observe the FASD interdisciplinary diagnostic team conduct an FASD diagnostic evaluation using the FASD 4-Digit Code.

| Start Date of Observational Activity: | End Date of Observational Activity: |
|---|---|
| | |

I understand the observational activity provided is done as a public service in the interest of medical education.

I understand the observational activity provided does not permit photography by the observer.

I understand that all information about patients, whether it is medical or personal, is absolutely confidential. I have read and signed the confidential acknowledgement.

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.

I agree to the following statements:

- My required immunizations are current
- I have not had any exposure to measles, rubella or chickenpox in the last 30 days.

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.

**Signature of applicant:** Date:

Parental Permission for Minors (for applicants under 18 years of age)

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:

## 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 healthcare professional for a specified period in a healthcare facility. During this time you will or may be seeing patients with a variety of medical issues and/or you may see, hear, or have access to 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.
- I understand that it is my responsibility to protect patient information, confidential information, restricted information, and/or proprietary information even after end date of observational activity. It is unlawful to use or disclose UW Medicine patient information, confidential information, restricted information, and/or proprietary information for any unauthorized purpose.

| **Signature of applicant:** | Date: |
|---|---|

| Medical Staff Approval | |
|---|---|
| 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. The supervising Physician should introduce the visitor to patients. 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**<br>**B. If no, please explain who will supervise the person observing?** | |
| **Supervising Provider Name:** | Date: |
| **Supervising Provider Signature:** | |

| Non-Medical Staff Approval | |
|---|---|
| I understand that I will be responsible for this person for the duration of this observational activity. | |
| **Supervising Non-Medical Name:** Susan Hemingway, Director FASDPN Clinic | Date: |
| **Supervising Non-Medical Signature:** | |

| Medical Director Approval | |
|---|---|
| **Signature:** | Date: |
| Thomas O. Staiger, UWMC Medical Director | |

| | |
|---|---|
| ☑ 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:** | Date: |

# COVID-19 Vaccination

Attach a copy of your proof-of-immunization to application (separate files will not be accepted).

**NOTE: Self-reported vaccine history is not acceptable proof of immunity. Applications missing vaccine history will not be accepted.**

**REQUIRED VACCINE:**

- **COVID-19** - Record of two doses of Moderna or Pfizer vaccine or one dose of Johnson & Johnson vaccine. **Observation cannot begin until two weeks after 2nd dose of Moderna or Pfizer vaccine or dose of Johnson & Johnson vaccine.**

# Observer Attestation Form

To keep all healthcare personnel and our patients safe, all UW Medicine observers are being asked to sign this document**.**

***UWMC has a policy against reporting to work if staff are sick. By signing the below, you are attesting that you will not come to the medical center to observe if you have any of the symptoms below (unless attributable to another known medical condition) and that you that you are free of these symptoms every day you observe:***

- Cough
- Shortness of breath or difficulty breathing
- Fever or chills
- Fatigue
- Muscle or body aches/pain
- Sore Throat
- New loss of taste or smell
- Gastrointestinal symptoms (such as nausea, vomiting, diarrhea)
- Headache
- Congestion or runny nose

Additionally, ***you may not come to observe if***:

- You have had direct contact with a person with COVID-19 within the past 14 days of your observational activity
- You have tested positive for COVID-19 in the 10 days prior to your observational activity
- You have been advised to home-quarantine by anyone 14 days prior to your observational activity

| | |
|---|---|
| **Date:** | |
| **Name:** & Signature | |
| **Department Where Observing:** | FASDPN Clinic |

*Thank you for helping keep our patients and staff safe!*