UW Medicine
UNIVERSITY OF WASHINGTON
MEDICAL CENTER

NOTE:

- There is a three-week processing time for applications.
- All application pages and immunization records must be sent in one complete PDF, separate files will not be accepted.
- Virtual observations are exempt from vaccination requirements.
- To submit your completed application, please email: **fasdclin@uw.edu**

Fill out the information below:

Observation Site: ☑ Montlake ☐ Northwest ☐ Ambulatory Clinic ☐ Virtual

Observer's Name:

Supervising Provider's Name: Dr. Susan Hemingway

Supervising Department: CHDD/FAS DPN

Badge Title: OBSERVER

End Date of Observation:

Observer Administration Use Only Date Approved:	
Thomas Staiger, MD UWMC Medical Director, Montlake Campus	Santiago Neme, MD UWMC Medical Director, Northwest Campus
Cindy Sayre, RN, PhD UWMC Chief Nursing Officer, Montlake Campus	Cindy Sayre, RN, PhD UWMC Chief Nursing Officer, Montlake Campus
Thomas Hei, MD UWMC Associate Medical Director, Ambulatory Services	Jenny Brackett Assistant Administrator, Ambulatory Services

Public Safety: When signed by the UWMC Medical Director/Chief Nursing Officer, this page acts as authorization for the person named above to receive an Observer badge. Do not issue a badge unless the UWMC Medical Director's/Chief Nursing Officer's signature is placed above.

Step 1: Applicant Biographical Information

Name:

Email:

Address:

City, State:

Zip Code:

Country:

Are you 18 years of age or older? ◯ Yes ◯ No

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

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

Read and Sign Below:

- *I understand the observational activity provided is done as a public service in the interest of medical education. I understand that the observational activity 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 attached confidential acknowledgment form.*
- *I understand that as an observer, regardless of background and training. I may not perform any medical procedures. I will not have direct contract 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.*

Applicant's Signature Date

If you are under 18 years of age, please have your legal guardian read and sign below:

Guardian permission: _____ 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.

Applicant's Guardian Signature Date

Step 2: Confidentiality Agreement

Read and Sign below:

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.*

Applicant's Signature Date

Reason for requesting observational activities:

- ○ I am a medical professional (e.g. physician, ARNP, PA, Nurse, Medic) seeking additional experience.
- ○ 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.
- ○ I am a potential medical school student who seeks observation hours or shadowing experience.
- ○ Other, please explain in detail:

Step 3: Supervision

Fill out the information below:

Who will you be observing? Dr. Susan Hemingway and FAS DPN Team

What department or unit are they with? CHDD/FAS DPN

What is their email? astley@uw.edu

What is their role?

- ○ MD/Medical Staff
- ○ RN/Other Patient Care Services
- ◉ Other: Director, MD and Clinicians

What is the first day of your observational activity?

What is the last day of your observational activity?

Have the UWMC employee supervising your observation read and sign below:

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 will introduce the visitor to patients. I also attest that I will receive the permission of the patient(s) for this person to observe.

UWMC Clinical Staff Supervisor Signature Date

If you are observing more than one provider within the SAME department, please fill out the information below and have them sign agreement to the above statement. When shadowing multiple provides at the same time, please submit a new application for different departments.

Additional Supervisor	Supervisor's Role	Signature & Date
Additional Supervisor	Supervisor's Role	Signature & Date
Additional Supervisor	Supervisor's Role	Signature & Date

Step 4: 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 (MM/DD/YYYY):	
Signature:	
Department Where Observing:	CHDD / FAS DPN Clinic

Thank you for helping keep our patients and staff safe!

Step 5: Tuberculosis Symptom Survey

Today's Date (MM/DD/YYYY): _____ Date of Birth (MM/DD/YYYY): _____

_____

Last Name
(Please print or type)

First Name

MI

If at any time during your observation period you experience these symptoms, please notify the Employee Health Center (206) 598-7971.

Do you have any of the following symptoms?	**YES**	**NO**
Productive cough lasting longer than two weeks	○	○
Hemoptysis (coughing up blood)	○	○
Recent unexplained weight loss	○	○
Night Sweats	○	○
Fever	○	○
Loss of appetite	○	○
Lethargy/Weakness	○	○

If you answered 'yes' to any of the above statements, please describe your symptoms further in the space below. When did the symptoms begin?

Have you sought treatment? If yes, what treatment have you received?

Step 6: Immunization History

Gather documentation of your immunity to each item on the checklist below and attach them to the application. Please note:

- Self-reported vaccine history is not acceptable proof of immunity. Applications missing vaccine history will not be accepted.
- If applicable, it is the responsibility of the observer to provide translated immunization records. Records must be translated by a medical provider or healthcare facility, not an observer.
- All applications and immunization records must be sent in one complete PDF, separate files will not be accepted. Please submit the entire application as one PDF for review.

REQUIRED VACCINES:

- **COVID-19** –
  - Record of two doses of Moderna or Pfizer vaccine, or one dose of Johnson & Johnson vaccine or vaccines listed for emergency use by "World Health Organization" WHO.
  - **And** a current COVID Bivalent-Booster (after 9/1/2022) per CDC guidance.
    - Stay Up to Date with COVID-19 Vaccines Including Boosters | CDC
- **Rubeola and Mumps** – Record of two vaccines with first dose on/after age one and second dose at least 28 days after first dose or positive IgG titer.
- **Rubella** – Record of one dose of Rubella vaccine or positive IgG titer.
- **Varicella** – Record of two vaccines with first dose on/after age one and second dose at least 28 days after first dose or positive titer. **Record of past infection is not sufficient documentation.**
- **Tetanus, Diphtheria and Pertussis** – Record of single dose of Tdap vaccine or TD-containing vaccine (DTaP, DTP, TD, Tdap) within the last ten years.
- **Influenza** – Flu vaccine for current season (required from October 1st-April 30th observation period)
- **Hepatitis B** – Although your exposure risk to Hepatitis B as an observer at UWMC is extremely low, we recommend that you be vaccinated. Please complete one of the following:
  - Provide proof of Hepatitis B Vaccine series
  - Provide proof of positive Hepatitis B titer
  - Review the latest CDC educational material on Hepatitis B and sign Hepatitis B Declination Form (both attached)

UW Medicine
UNIVERSITY OF WASHINGTON
MEDICAL CENTER

Employee Health Center

Hepatitis B Vaccine and/or Titer Declination

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine and/or be provided the opportunity to check my status by having a titer drawn. However, I decline hepatitis B vaccination and/or titer at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease.

I have been offered the opportunity to review the latest CDC educational material (Vaccine Information Sheet Hepatitis B) and ask questions regarding:
1) Hepatitis B virus and the risks to health care personnel, and
2) the potential risks and benefits of the Hepatitis B vaccine for myself and patients.

If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine or have titers drawn, I can receive the vaccination series or titers at that time at no cost to me.

Please print clearly:

Last Name First Name Middle Initial

Signature Date Signed

Form updated: 8/06/2019

VACCINE INFORMATION STATEMENT

Hepatitis B Vaccine:

What You Need to Know

Many vaccine information statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1. Why get vaccinated?

Hepatitis B vaccine can prevent **hepatitis B**. Hepatitis B is a liver disease that can cause mild illness lasting a few weeks, or it can lead to a serious, lifelong illness.

- **Acute hepatitis B infection** is a short-term illness that can lead to fever, fatigue, loss of appetite, nausea, vomiting, jaundice (yellow skin or eyes, dark urine, clay-colored bowel movements), and pain in the muscles, joints, and stomach.
- **Chronic hepatitis B infection** is a long-term illness that occurs when the hepatitis B virus remains in a person's body. Most people who go on to develop chronic hepatitis B do not have symptoms, but it is still very serious and can lead to liver damage (cirrhosis), liver cancer, and death. Chronically infected people can spread hepatitis B virus to others, even if they do not feel or look sick themselves.

Hepatitis B is spread when blood, semen, or other body fluid infected with the hepatitis B virus enters the body of a person who is not infected. People can become infected through:

- Birth (if a pregnant person has hepatitis B, their baby can become infected)
- Sharing items such as razors or toothbrushes with an infected person
- Contact with the blood or open sores of an infected person
- Sex with an infected partner
- Sharing needles, syringes, or other drug-injection equipment
- Exposure to blood from needlesticks or other sharp instruments

Most people who are vaccinated with hepatitis B vaccine are immune for life.

2. Hepatitis B vaccine

Hepatitis B vaccine is usually given as 2, 3, or 4 shots.

Infants should get their first dose of hepatitis B vaccine at birth and will usually complete the series at 6–18 months of age. **The birth dose of hepatitis B vaccine is an important part of preventing long-term illness in infants and the spread of hepatitis B in the United States.**

Children and adolescents younger than 19 years of age who have not yet gotten the vaccine should be vaccinated.

Adults who were not vaccinated previously and want to be protected against hepatitis B can also get the vaccine.

Hepatitis B vaccine is also recommended for the following people:

- People whose sex partners have hepatitis B
- Sexually active persons who are not in a long-term, monogamous relationship
- People seeking evaluation or treatment for a sexually transmitted disease
- Victims of sexual assault or abuse
- Men who have sexual contact with other men
- People who share needles, syringes, or other drug-injection equipment
- People who live with someone infected with the hepatitis B virus
- Health care and public safety workers at risk for exposure to blood or body fluids
- Residents and staff of facilities for developmentally disabled people
- People living in jail or prison
- Travelers to regions with increased rates of hepatitis B

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

- People with chronic liver disease, kidney disease on dialysis, HIV infection, infection with hepatitis C, or diabetes

Hepatitis B vaccine may be given as a stand-alone vaccine, or as part of a combination vaccine (a type of vaccine that combines more than one vaccine together into one shot).

Hepatitis B vaccine may be given at the same time as other vaccines.

3. Talk with your health care provider

Tell your vaccination provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of hepatitis B vaccine**, or has any **severe, life-threatening allergies**

In some cases, your health care provider may decide to postpone hepatitis B vaccination until a future visit.

Pregnant or breastfeeding people should be vaccinated if they are at risk for getting hepatitis B. Pregnancy or breastfeeding are not reasons to avoid hepatitis B vaccination.

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting hepatitis B vaccine.

Your health care provider can give you more information.

4. Risks of a vaccine reaction

- Soreness where the shot is given or fever can happen after hepatitis B vaccination.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

5. What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call **9-1-1** and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at **www.vaers.hhs.gov** or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff members do not give medical advice.*

6. The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Claims regarding alleged injury or death due to vaccination have a time limit for filing, which may be as short as two years. Visit the VICP website at **www.hrsa.gov/vaccinecompensation** or call **1-800-338-2382** to learn about the program and about filing a claim.

7. How can I learn more?

- Ask your health care provider.
- Call your local or state health department.
- Visit the website of the Food and Drug Administration (FDA) for vaccine package inserts and additional information at **www.fda.gov/vaccines-blood-biologics/vaccines**.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636** (**1-800-CDC-INFO**) or
  - Visit CDC's website at **www.cdc.gov/vaccines**.