Dear potential observer;

For many, healthcare is not just a job or a profession, it's a true calling. At Wesley, we're always looking for the next generation of those interested in healthcare. You're likely reading this because you have a desire to learn more about healthcare as a career.

To observe at Wesley Medical Center you must be an undergraduate student. When you observe, you'll be able to spend time with someone in your desired area of healthcare.

If you're interested, please follow the instructions in this packet. It contains important information, documents you need to complete, and other requirements you must complete before you can observe at Wesley. If you have any questions along the way, email Observations@Wesleymc.com and we'll be happy to answer them for you.

Please return all documents in a single PDF file. If you submit your paperwork and it's incomplete, we will not be able to process your request. So double check you have the necessary paperwork. When the paperwork is completed, please save it as a single PDF file and email it to Observations@Wesleymc.com.

We must receive your paperwork at least two weeks prior to the beginning of your observation experience so we have time to ensure you have a good experience.

Thanks again for your interest. We're excited for your future in the healthcare profession.

Wesley Clinical Education

Observation Guidelines and Requirements

- Complete attached documents
- Paperwork is due back at least **2 weeks prior** to start of experience
- Include a copy of your driver's license or school issued photo ID
- Vaccination page is the hardest page to complete. A physician, nurse or clinic must complete, then give back to you to send in with other paperwork.
    - Must have titers for varicella and MMRs if you did not receive 2 vaccinations
- Save the paperwork in a single PDF file and email it to Observations@Wesleymc.com. When emailing, your PDF file name should be your name in this format – *Last, First (Jones, Michael)*. Your email subject line should be the location and your desired observation area (*Woodlawn Acute Care).*
- Observation is limited to a maximum of 8 hours. Your observation time may be shorter. At the discretion of the department.
- If you know the individual or department you would like to observe, you're encouraged to contact them directly. If you need a name and contact information, we're happy to assist with that.
- **PLEASE NOTE:** We do not make arrangements for observations with physicians, physician's assistants, and nurse practitioners. You must find that connection yourself and secure their permission. We may contact them to verify they approved your observation.
- You must wait a minimum of 6 months between observation requests
- You will be issued a badge. You are required to wear it at all times while you are observing at Wesley.
- Return badge when done

Your appearance while at Wesley Medical Center should be appropriate. Please wear scrubs or business casual. If your attire is not appropriate, you will be sent home.

- **Parking**: Please park in the visitor parking garage at the corner of Hillside and Murdock (no charge). Enter the hospital thru the glassed in entry way, taking a left into the hospital. There is signage above the doorway.
- **Name badge**: You will be issued a badge by the Department to wear while in the hospital. Please return the badge to the Department once the observation is completed.
- **Communication**: If you are unable to come as planned or will be late, contact the department you plan to observe. If you wish to reschedule, please contact the Clinical Education department by emailing Observations@Wesleymc.com

Please make sure we have all your information, including your emailed government or school issued photo ID, along with your Health/Vaccination Record a minimum of two weeks prior to starting your observation experience at Wesley Medical Center.

Thank you for considering Wesley Medical Center for this observation experience. If you have additional needs, please email Observations@Wesleymc.com.

Thank you,

Wesley Clinical Education

WESLEY MEDICAL CENTER
EDUCATION

INSTRUCTIONS TO COMPLETE ATTACHED PAPERWORK

Use this page as a reference for all the necessary paperwork you need to complete in order to observe at Wesley. There are four documents you will need to fill out and save as a single PDF and email to Observations@Wesleymc.com. Please see Observation Guidelines and Requirements for how to name your PDF file and what to put in your email subject line.

REQUIRED DOCUMENTS TO COMPLETE AND RETURN

- ☐ Observation Request Form:
  - Complete front and back
- ☐ Health Record Verification:
  - Must be completed by a doctor, RN or school nurse
  - All requested health information must be verified and up to date
  - Once completed, include this with the other documents. DO NOT HAVE DOCTOR, RN OR SCHOOL NURSE SEND THIS SEPARATELY

  If you have not had a current TB screening within the last year, you must have one done and read BEFORE you can come for an observation.

- ☐ Hospital Safety Information
  - Review the first page, then complete the bottom of the second page
  - You only need to send the second page
- ☐ Confidentiality and Security Agreement
  - Sign the Confidentiality and Security Agreement form indicating you have received information on PHI, and will abide by it.
- ☐ Appendix A – Acknowledgement of Observer
- ☐ Copy of ID

REQUIRED DOCUMENT TO REVIEW

- ☐ HIPAA/HITECH Privacy Training
  - Review and become familiar with PowerPoint
  - \\Hca\wmdc\SHR\CME\Students\Observation-Shadowing Paperwork\Customizable HIPAA and HITECH Privacy Training PPT.pptx

ALL PAPERWORK MUST BE COMPLETED AND EMAILED/FAXED A MINIMUM OF 2 WEEKS PRIOR TO STARTING YOUR OBSERVATION EXPERIENCE.

EMAIL COMPLETED DOCUMENTS, AS A PDF FILE TO OBSERVATIONS@WESLEYMC.COM.

WESLEY Healthcare

****RETURN THIS DOCUMENT 1 of 5****

The following information will be needed to obtain hospital approval for this request. Please submit this request along with the attached paperwork.

Today's Date _____

Name: _____

Date of Birth: _____

Address: _____

City/State/Zip Code: _____

Cell Phone: _____

Email Address: _____

Contact person in case of emergency: Name _____
Phone _____
Relationship _____

REQUEST INFORMATION – COMPLETE QUESTIONS 1 & 2 IF ONLY DOING AS PART OF SCHOOL REQUIREMENT:

1. Name of school/sponsoring agency:_____

   Contact person_____ Phone_____

2. School Name: _____High School _____College

   Other (specify)_____

EVERYONE COMPLETE QUESTIONS 3– 7!!

Outline your request:

3. Area of the hospital requested for observation:_____
4. How many hours/days are desired:_____
   NOTE: Maximum of 8 hours allowed for observation experiences
5. Desired Observation Date – must be approved by WMC
   a. Date_____
6. List 3 objectives for this experience:

   _____

   _____

   _____

7. How do you plan to use the knowledge gained from this experience?

   _____

   _____

   _____

WESLEY Healthcare

Authorization for Observation

Required For Observing with Physicians, Physician's Assistants or Nurse Practitioners

The following individual has requested to observe with me within Wesley Medical Center facilities. I voluntarily agree to have this individual observe with me on the date below.

(To be completed by the individual)

Individual Requesting Observation:

Name_____

Address_____

Cell Phone Number_____

Observation date_____

(To be completed by the provider and given to individual)

Approved by

Name_____

Signature_____

Email or cell phone to verify approval_____

Thank you for allowing this individual to observe with you.

Tammy Gage, BBA,
CME Coordinator | Student Placement Coordinator
Wesley Medical Center
Medical Staff Office
Tammy.Gage@wesleymc.com

HEALTH RECORD VERIFICATION FORM

Name:_____
Address:_____
Phone: _____

This must be verified and documented by a physician, an RN or school nurse. **We will not accept a note from a physician stating you have had Chicken Pox/Varicella. You must have 2 (two) vaccinations or a positive titer.**

1) **Tuberculosis Screening** (Required within last 12 months)
Date_____Results _____

2) **Measles, Mumps & Rubella**

☐ "Positive" MMR titers documentation (all 3 titers)
(date) _____

OR

☐ Documentation of 2 MMR's
(1) Age_____(Date) _____
(2) Age_____(Date) _____

3) **Chicken Pox (Varicella)**

☐ "Positive" Varicella titer documentation
(Date) _____

OR

☐ Documentation of two (2) immunizations
(1) Age_____(Date) _____
(2) Age_____(Date) _____

4) **Tetanus Toxoid, Diptheria and Pertussis**

☐ Documentation of **one** booster dose of **Tdap** vaccine within last 10 years.
Date given: _____

5) **Transmissible Infections:** student states no known infection as of
Date: _____

6) **Seasonal Flu Vaccination Received:**
Date: _____
(required if observation between November 1st thru March 31st)

Completed by:_____Date:_____

Agency or Office:_____Phone:_____

Address:_____

HOSPITAL SAFETY INFORMATION FOR OBSERVATION EXPERIENCE

Please review the following information on safety procedures.

Exposure Control Plan / Standard Precautions

- A clear plastic bag containing personal protective equipment (PPE) and a resuscitation device is located in all patient rooms and non-patient care areas. This equipment is to be worn when there isa risk of exposure to body fluids or secretions while providing care.

- If an exposure incident involving body fluids or secretions occurs, report it immediately to your instructor, preceptor or department manager. You will be sent to the Employee Health Department for evaluation and follow up. You will be assisted with the completion of the required documentationfor this exposure.

Hand Hygiene

- A key piece in preventing spread of bacteria and infectious organisms is the **consistent** practice ofhand hygiene. Acceptable forms of hand hygiene include the use of soap and water as well as alcohol based hand gel. Perform hand hygiene immediately after removing PPE (including gloves)and between each patient contact.

- Do this with **EVERY PATIENT. EVERY CONTACT. EVERY TIME!!!**

Hazardous Materials

- Material Safety Data Sheets (MSDS) provide information about hazardous chemicals at Wesley. AnMSDS can be obtained from the Security Department.

Risk Management/ Response to Emergencies

- Notify your instructor, preceptor or department manager if you see an unusual occurrence involvingemployees, patients, visitors or encounter an environmental situation of concern. You will be assisted with completion of the paperwork needed to document this situation.

- In the event of an emergency, call *23131 from any Wesley phone to report a concern.

RETURN THIS DOCUMENT 3 of 5

WESLEY HEALTHCARE
HOSPITAL SAFETY INFORMATION & ATTESTATION
FOR OBSERVATION EXPERIENCE

HOSPITAL SAFETY INFORMATION

I have received and reviewed the following information prior to starting my clinical observation experience at Wesley Healthcare. I know the phone number to report emergencies (*23131) and to whom I should report safety concerns.

- Exposure Control Plan/Standard Precautions
- Hand Hygiene
- Hazardous materials
- Risk Management/ Response to Emergencies
- Response to Emergencies

VERIFICATION OF REVIEW FOR OBSERVATION STUDENTS

I have received and reviewed the following information prior to starting my clinical observation experiences at Wesley Medical Center.

- HIPAA/HITECH Privacy Training PowerPoint
- Understand that observation is limited to 8 hours
  - Divided over no more than 2 days
- Wearing appropriate attire as described in the packet

Student Signature_____

Date_____

School / Agency_____

WESLEY Healthcare

****RETURN THIS DOCUMENT 4 of 5****

Confidentiality and Security Agreement

I understand that the Hospital or business entity (the "Hospital") for which I work, volunteer or provide servicesmanages health information as part of its mission to treat patients. Further, I understand that the Hospital has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentialityof their patients' health information. Additionally, the Hospital must assure the confidentiality of its human resources, payroll, fiscal, research, internal reporting, strategic planning information, or any information that contains Social Security numbers, health insurance claim numbers, passwords, PINs, encryption keys, creditcard or other financial account numbers (collectively, with patient identifiable health information, "Confidential Information").

In the course of my employment/assignment at the Hospital, I understand that I may come into the possession of this type of Confidential Information. I will access and use this information only when it is necessary to perform my job related duties in accordance with the Hospital's Privacy and Security Policies, which are available on the Hospital intranet (on the Security Page) and the Internet (under Ethics & Compliance). I further understand that I must sign and comply with this Agreement in order to obtain authorization for access to Confidential Information or Hospital systems.

General Rules:

1. I will act in the best interest of the Hospital and in accordance with its Code of Conduct at all timesduring my relationship with the Hospital.
2. I understand that I should have no expectation of privacy when using Hospital information systems. The Hospital may log, access, review, and otherwise utilize information stored on or passing through its systems, including email, in order to manage systems and enforce security.
3. I understand that violation of this Agreement may result in disciplinary action, up to and includingtermination of employment, suspension, and loss of privileges, and/or termination of authorizationto work within the Hospital, in accordance with the Hospital's policies.

Protecting Confidential Information:

1. I understand that any Confidential Information, regardless of medium (paper, verbal, electronic, image or any other), is not to be disclosed or discussed with anyone outside those supervising, sponsoring or directly related to the learning activity.
2. I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know it. I will not take media or documents containing Confidential Information home with me unless specifically authorized to do so as part of my job. Case presentation material will be used in accordance with Hospital policies.
3. I will not publish or disclose any Confidential Information to others using personal email, or to anyInternet sites, or through Internet blogs or sites such as Facebook or Twitter. I will only use suchcommunication methods when explicitly authorized to do so in support of Hospital business and within the permitted uses of Confidential Information as governed by regulations such as HIPAA.
4. I will not in any way divulge, copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized. I will only reuse or destroy media in accordance with Hospital Information Security Standards and Hospital record retention policy.

5. In the course of treating patients, I may need to orally communicate health information to or about patients. While I understand that my first priority is treating patients, I will take reasonable safeguards to protect conversations from unauthorized listeners. Whether at the School or at theHospital, such safeguards include, but are not limited to: lowering my voice or using private roomsor areas (not hallways, cafeterias or elevators) where available.
6. I will not make any unauthorized transmissions, inquiries, modifications, or purgings of Confidential Information. I will not access data on patients for whom I have no responsibilities ora need-to-know the content of the PHI concerning those patients.
7. I will not transmit Confidential Information outside the Hospital network unless I am specifically authorized to do so as part of my job responsibilities. If I do transmit Confidential Information outside of the Hospital using email or other electronic communication methods, I will ensure thatthe Information is encrypted according to Hospital Information Security Standards.

Following Appropriate Access:

1. I will only access or use systems or devices I am officially authorized to access, and will not demonstrate the operation or function of systems or devices to unauthorized individuals.
2. I will only access software systems to review patient records or Hospital information when I havea business need to know, as well as any necessary consent. By accessing a patient's record or Hospital information, I am affirmatively representing to the Hospital at the time of each access that I have the requisite business need to know and appropriate consent, and the Hospital may rely on that representation in granting such access to me.

Using Portable Devices and Removable Media:

1. I will not copy or store Confidential Information on removable media or portable devices such as laptops, personal digital assistants (PDAs), cell phones, CDs, thumb drives, external hard drives,etc., unless specifically required to do so by my job. If I do copy or store Confidential Information on removable media, I will encrypt the information while it is on the media according to Hospital Information Security Standards
2. I understand that any mobile device (Smart phone, PDA, etc.) that synchronizes Hospital data (*e.g.*, Hospital email) may contain Confidential Information and as a result, must be protected. Because of this, I understand and agree that the Hospital has the right to:
    a. Require the use of only encryption capable devices.
    b. Prohibit data synchronization to devices that are not encryption capable or do not supportthe required security controls.
    c. Implement encryption and apply other necessary security controls (such as an access PIN and automatic locking) on any mobile device that synchronizes Hospital data regardless ofit being a Hospital or personally owned device.
    d. Remotely "wipe" any synchronized device that: has been lost, stolen or belongs to a terminated employee or affiliated partner.
    e. Restrict access to any mobile application that poses a security risk to the Hospital network.

WESLEY Healthcare

Doing My Part – Personal Security:

1. I understand that I will be assigned a unique identifier (*e.g.*, 3-4 User ID) to track my access and use of Confidential Information and that the identifier is associated with my personal data provided as part of the initial and/or periodic credentialing/employment verification process.
2. I will:
   a. Use only my officially assigned User-ID and password [and/or token (*e.g.*, SecurIDcard)].
   b. Use only approved licensed software.
   c. Use a device with virus protection software.
3. I will never:
   a. Disclose passwords, PINs, or access codes.
   b. Use tools or techniques to break/exploit security measures.
   c. Connect unauthorized systems or devices to the Hospital network.
4. I will practice good workstation security measures such as locking up diskettes when not in use, using screen savers with activated passwords, positioning screens away from public view.
5. I will immediately notify my manager, Hospital Information Security Official (FISO), Director of Information Security Operations (DISO), or Hospital or Corporate Client Support Services (CSS)help desk if:
   a. my password has been seen, disclosed, or otherwise compromised;
   b. media with Confidential Information stored on it has been lost or stolen;
   c. I suspect a virus infection on any system;
   d. I am aware of any activity that violates this agreement, privacy and security policies; or
   e. I am aware of any other incident that could possibly have any adverse impact on Confidential Information or Hospital systems.

Upon Termination:

1. I agree that my obligations under this Agreement will continue after termination of my employment,expiration of my contract, or my relationship ceases with the Hospital.
2. Upon termination, I will immediately return any documents or media containing ConfidentialInformation to the Hospital.
3. I understand that I have no right to any ownership interest in any Confidential Informationaccessed or created by me during and in the scope of my relationship with the Hospital.

By signing this document, I acknowledge that I have read this Agreement and I agree to comply with all theterms and conditions stated above.

Signature	Wesley Healthcare 31608	Date
Printed Name	School Name / Business Name	

Return all 3 pages of this agreement

WESLEY Healthcare

**** RETURN THIS DOCUMENT 5 OF 5 ****

Attachment A

ACKNOWLEDGEMENT OF RESPONSIBIILITIES OF OBSERVER AND WAIVER AND RELEASE

I, _____ have voluntarily requested to
(print name)
observe at _____

_____
(department/unit name and procedure, etc.)
on _____.

I have read and understand the responsibilities of an observer. I agree to abide by and assume the following responsibilities:

- Everything I see and hear is strictly confidential. I must maintain confidentiality and adhere to HIPAA Guidelines.
- I am only observing and cannot provide patient care.
- I am not allowed to read patient records.
- There are inherent risks; hazards and dangers in hospitals, which are potentially a threat to the health and safety of observers, such as, but not limited to blood exposure and infectious disease processes.

Being fully aware of such possible risks, hazards and dangers, I voluntarily elect to be an observer and assume all risks of loss, damage, and injury, including disability or death that may be sustained by me as a result of my observation experience.

In consideration of the facility's acceptance of my observation request, I, intending to be bound for myself, my heirs, executors, administrators and assigns, hereby release and discharge Wesley Medical Center, LLC, d/b/a, Wesley Medical Center, its agents, officers, employees, affiliates, members, successors and assigns from any and all liability, claims, damages, demands or causes of action that may arise as a result of my observation experience, for any loss, damage, injury, including disability or death, arising out of my observation experience.

_____
Signature

_____
Signature of Parent (if Observer is under 18)

_____
Address

_____
Email Address

_____ _____
Phone Date

_____
Signature of Employee Coordinating Observation Experience

_____ _____
Printed Name of Employee Phone/Department

** RETURN THIS DOCUMENT COVERSHEET**

WESLEY OBSERVATION CHECKLIST

Use this page as a cover sheet for your completed paperwork. This should also act as a checklist to makesure you have everything you need for your observation request.

☐ Observation Request Form

☐ Health Record Verification Form

☐ Hospital Safety Information & Attestation for Observation Experiences

☐ Confidentiality and Security Agreement

☐ Attachment A – Acknowledgement of Observer

☐ Copy of your government or school issued photo ID

All documents should be saved and combined into a single PDF file. The PDF file name should be your name in this format: *Last Name, First Name*. Your email subject line should be the location and your desired observation area: e.g. *Woodlawn Acute Care*. Remember, everything MUST be sent at the sametime, via email or fax. If you're unsure how to combine the documents into a single PDF file, contact yourschool's office to see if you can use their fax machine.

Hand delivered or incomplete applications will not be processed.

Once we have received and processed your application, we will notify you of the next steps. That could take anywhere from a few days to two weeks, that's why we need the application two weeksbefore your desired start date.

Include copy of your Driver's License or school issued ID.

Email:

Observations@Wesleymc.com