LSU Health SHREVEPORT

Application for Observer

NAME: _____ **LSUHS FACULTY SPONSOR:** _____
Last (Family, Surname) First (Given) Middle

PROPOSED APPOINTMENT DATES, FROM: _____ **TO:** _____ **LSUHS SCHOOL:** _____
month/day/year *month/day/year*

COUNTRY OF CITIZENSHIP: _____ **LSUHS DEPARTMENT/DIVISION:** _____

If you are a U.S. permanent resident, check here ☐

Required Documents Checklist Please submit a complete set of these application materials to your Faculty Sponsor.
The completed application form (pages 1-4)
Copy of photo identification:
For U.S. citizens: Copy of federal or state-issued photo identification
For U.S. permanent residents: Copy of Permanent Resident Card
For non-U.S. citizens: Copy of passport identification page, visa stamp, Immigration forms (I-20, DS-2019, I-797, etc.) and Form I-94 (if applicable)
Résumé or C.V. (in English, listing academic history, certifications, licensures, employment, and training experience)
Health form(s) *(with supporting documentation as requested on the form,including English translations, if applicable)*
Observer fee: non-refundable $500.00 USD application processing fee
For MD Observers in the clinical areas: Copy of diploma (highest degree) and documentation of graduation from a medical school listed in the International Medical Education Directory (IMED) (www.faimer.org). PLUS one of the following: 1. copy of score report demonstrating passing score on at least USMLE Step 1 and Step 2 CK or, 2. USMLE transcript, Educational Commission for Foreign Medical Graduates (ECFMG) Status Report or ECFMG Certificate or, 3. active, unrestricted US medical license or its equivalent in the country in which the applicant practices medicine. For **Observers from other Healthcare Professions** in clinical areas: Copy of diploma (highest degree) plus documentation of graduation from the appropriate professional school.
For Undergraduate Observers: Verification of enrollment from College/University Registrar and official college transcript

If you have questions concerning the status of your application at any time, please contact the Office of the Registrar.

Please allow minimum of six (6) weeks for the approval process. Application should be submitted no more than six (6) months prior the proposed dates.

Biographical Information - Please type or print legibly. If we can't read your writing, your application will be denied.

Full Legal Name: _____ _____
Last (Family, Surname) First (Given) Middle

Gender: ◯ Male ◯ Female Date of Birth: _____ ____
month / day/year

Permanent Mailing Address: _____
No. and Street Apartment No.

_____
City State/Province Zip/Postal Code Country

_____ _____
Phone E-mail Address

Emergency Contact Information: _____
Name Relationship Phone

Shreveport Area Address: _____
(if known, and if different from Permanent Address)
No. and Street Apartment No.

_____
City State Zip Code

_____ _____
Local Phone Number E-mail Address

Have you ever had a felony or equivalent criminal conviction? ◯ Yes ◯ No
If yes, attach details of conviction, including dates.

Have you ever studied, observed, worked, or volunteered at LSU Health? ◯ Yes ◯ No

If yes: In what capacity? (Student, Observer, Employee, Postdoctoral Fellow, Volunteer, etc.) _____

Dates: _____ -- _____ Name of Faculty Sponsor: _____
month/day/year – month/day/year

School/Department: _____

Statement of Intent

Please state the objectives of your association, as well as the benefits you expect to receive from this experience:

For foreign nationals who are not U.S. citizens or U.S. permanent residents:

Passport #: _____ Issued by: _____

Country of Birth: _____ Country of Last Legal Permanent Resident: _____

Country of Citizenship: _____

Do you currently have a U.S. visa? ○ Yes ○ No If yes, what type? _____ Exp. Date: _____ *month/day/year*

Are you currently in the U.S? ○ Yes ○ No If yes, I-94# (11-digits): _____ Exp. Date: _____ *month/day/year*

Do you have a U.S. Social Security Number? ○ Yes ○ No *If yes, you will be contacted at a later time to provide it directly for a background check (please do not write your U.S. Social Security number here).*

Please note:

- Foreign Nationals (non-U.S. citizens/permanent residents) may ***not*** begin their association with LSU Health until the their visas are reviewed and approved by the Office of Legal Affairs.
- ***Foreign Nationals (non-U.S. citizens/permanent residents) must have a valid U.S. immigration visa status necessary for the full period of the proposed visiting activity.***
- Applicants holding temporary visas are bound by the restrictions placed on LSU Health by the U.S. Department of Homeland Security and the U.S. Department of State.
- Please direct visa-related inquiries to Carol Peterson in the Office of Legal Affairs at 318.675.5571.

Acknowledgements - Read the following statements carefully before signing.

In consideration of LSU Health allowing me to participate in this association and for other good and valuable consideration, I agree and attest as follows:

A. I certify that I have requested and am entering into this association without any promise or expectation of financial compensation or offer of employment or other appointment by LSU Health.

B. I understand that all application material submitted to LSU Health becomes the property of LSU Health and is not returnable. I also understand that LSU Health is not obligated to furnish me with duplicate copies.

C. I understand that the information submitted herein will be relied upon by LSU Health to determine my status for eligibility for this association. I authorize LSU Health to verify the information I have provided. I understand that any omission of requested data may jeopardize my consideration for this association with LSU Health. I agree to notify the proper LSU Health officials of any changes in the information provided.

D. I release from liability and from any restrictions as to confidentiality or privacy all hospitals, schools, physicians, employers, individuals, agencies, or organizations that provide information about me at the request of LSU Health or its agents.

E. I affirm and agree that at all times during my association with LSU Health and at any time while on the premises of LSU Health, I will comply will all applicable federal, state and local laws and regulations and all policies and procedures of LSU Health.

F. I agree to complete at LSU Health any and all required training relevant to my association with LSU Health, including but not limited to training on safety, confidentiality, and

G. I am an Observer in a clinical setting, I will review and understand the LSU Health "*COMPLIANCE, HIPAA PRIVACY AND INFORMATION SECURITY SELF STUDY BASIC TRAINING GUIDE"* and, I agree to and will sign the "*COMPLIANCE AND HIPAA TRAINING ACKNOWLEDGEMENT*" document.

H. I agree to comply with the privacy and security rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and LSU Health's policies regarding the privacy of individually identifiable health information, including but not limited to those contained the "*Code of Conduct*", "*Ochsner LSU Health Shreveport Confidentiality Agreement*" and the "*Ochsner LSU Health System Healthcare Observer agreement" and "Ochsner LSU Health HIPPA Privacy and Security"* and will sign the relevant documents.

I. I understand that I may become aware of or acquire information that is the intellectual property of LSU Health and which may be proprietary in nature ("LSU Health IP"). This intellectual property may consist of unpublished results, know-how, non-patentable information, patentable or other written or orally transmitted information. I agree to hold all such LSU Health Intellectual Property in confidence and further agree that no LSU Health Intellectual Property that I have become aware of or that has been acquired by me will be transmitted by me in any form to a third party.

J. As a component institution of the University, LSU Health abides by Chapter VII of the Louisiana State University Board of Supervisors Bylaws and Regulations regarding Intellectual Property. To the extent that an invention or other intellectual property arises from my association with LSU Health, the invention and intellectual property will be automatically owned by the University. I agree to disclose promptly, in writing, and agree to assign and hereby do assign all rights in any and all inventions and creations, whether or not patentable, that are created by me during the term of this association (the "Intellectual Property") to the LSU Board of Supervisors, on behalf of LSU Health. I agree to sign any and all documentation that is required to perfect or evidence this assignment and all documents reasonably necessary for the Board and LSU Health to protect Intellectual Property.

K. I agree that I am not authorized to engage in (i) the diagnoses of disease or other conditions in humans; or (ii) the cure, mitigation, therapy, treatment, treatment planning, or prevention of disease in humans or to affect the structure or function thereof, irrespective of whether or not I am certified or qualified for any of the foregoing.

M. I represent and certify that (a) I am not a person who has been designated as a specifically designated national or blocked person under applicable U.S. law or regulation, and (b) neither I nor any entity with which I am employed or otherwise affiliated is (i) a person or entity with whom U.S. persons or entities are restricted from doing business under U.S. law, executive power, or regulation promulgated there under by any regulatory body, or (ii) in violation of any U.S. money laundering law.

N. I understand that I will be subject to a background check in accordance with LSU Health's policy on Criminal Background Checks (US Citizens and Permanent Residents).

O. I understand that my association with LSU Health may be revoked at any time by LSU Health without cause and without advance notice to me (including the application process).

P. I agree to indemnify and hold LSU Health and The University, the LSU Board of Supervisors, officers, agents, and employees, harmless from any loss, claim, damage, injury, or liability of any kind arising out of or in connection with my association with or presence at LSU Health.

Q. I certify that the information in the application is complete and correct to the best of my knowledge and belief. I acknowledge the submission of any false information is grounds for rejection of my application or termination of my association with LSU Health.

Signature of Applicant _____ **Date** _____

(hand written signature required)

The non-refundable application processing fee is required with the application.

O 500.00 USD paid via PayPal

For office use only **Payment received on:** _____ **by** _____

Please include all required documentation (see page 1) with this application and submit to the Faculty Sponsor or sponsoring department. ***NOTE:*** *Applications are reviewed and evaluated by the Provost for final approval. After this approval process, the Applicant may come to LSU Health for the Purposes stated herein, contingent upon an appropriate visa being obtained (if applicable) and any additional agreements being successfully executed (if applicable). Once all the paperwork is in order, the Applicant must also complete the following intake process* ***before starting the visit****:*

1) Check-in with the Office of the Registrar for ID badge and complete Compliance Paperwork

Observership Contract

The Federal Health Insurance Portability and Accountability Act (HIPAA) and related laws and regulations were established to preserve the confidentiality of medical and personal information, in addition, to specify that such information may not be accessed, used, disclosed or viewed except as authorized by law or unless authorized by the patient. These privacy laws and regulations apply to all Health System personnel including students and observers. All students / observers are required to agree to and sign this confidentiality statement.

I understand as a clinical observer, I am not permitted to have direct patient contact or to practice medicine. I acknowledge that I do not have medical staff privileges to practice medicine at Ochsner LSU Health. I understand that as an observer, I am not permitted to participate in direct or indirect patient care activities. These restricted activities include but are not limited to hands-on patient care or medical equipment, access to medical information (medical charts, computer work stations, electronic medical record), instruments, medications, infusions, intravenous liquids, lab testing equipment, etc.

I understand that, as an observer for clinical purposes, I may see or hear confidential information, such as medical information about a patient, verbal discussions about patient care, and electronic communications that include confidential patient information.

I acknowledge that it is my responsibility to respect the privacy and confidentiality of patient information and other personally identified information. I will not access, use, or disclose any confidential information outside of my educational experience at Ochsner LSU Health. I will not photograph, videotape or photocopy any patients or patient information.

I understand that if I breach any provision of this Agreement, I may be subject to civil or criminal liability under HIPAA. Failure to abide by these guidelines will result in the immediate termination of the observership.

I understand I may not take part in any form of research.

I understand that I must remain with my sponsor (or his/her designee) while in patient care areas – I am not permitted to move freely around the hospital or the medical school.

Observer's Name (*Please Print*): _____

Observer's Signature: _____

Date: _____

Certificate of Health Statement

For Non-Employee Medical Clearance

Name: _____ DOB: _____Today's Date: _____

Email: _____ SS#: _____ (last four digits) **OR** Passport#_____

LSUHS Dept: _____ Contact Person and Phone #: _____

LSUHS Activity: **Observership** Begins: _____Ends: _____

Section I: **TO BE COMPLETED BY HEALTH CARE PROVIDER**: This form must be completed in its entirety with **required documentation attached** as stated. Failure to provide this information accurately will result in denial of your observership.

1. Tuberculin Skin Test (Mantoux) (must be within 12 months):

   Date Placed:_____Manufacturer: _____Lot/Exp. #: _____

   Date Read: _____Reaction (mm): _____

   (10mm or greater is considered Positive; Chest X-ray required)

   If Positive TST: Chest X Ray required *: Date:_____Result: _____

   (must be within 12 months)

2. **MMR –**2 doses of MMR vaccine **or you must provide documentation of titer results** of Rubella and Rubeola

   MMR Dose #1 ____/____/____ MMR Dose #2 ____/____/____

   Rubella (German measles): IgG Antibody Titer: Date:_____Result: _____

   Rubeola (Measles): IgG Antibody Titer: Date:_____Result: _____

3. Varicella: Disease? Yes / No (circle one).
   If no, need dates of two Varicella Vaccines (1) _____2)_____ or **documentation of**

   Varicella Titer results (date/result): _____

4. Tetanus/Diphtheria/Pertussis (TDap) (within the past 10 years) Vaccination Date: _____
5. COVID vaccine: vaccination date: dose #1_____ dose#2_____
   Copy of vaccine card required

6. Influenza vaccine: vaccination date: _____

The dose is mandatory for observerships from October 1st through March 31st and must be for the current flu season .

Required: This section must be signed and certified that the health information above is accurate.

Provider Name (print): _____ Signature: _____Date: _____

Address: _____ Phone: _____

Provider's Stamp:

Updated 2/17/22