

OBSERVER APPLICATION

This form should be submitted at least 24 hours prior to potential observance.

Name: _____

Organizational affiliation (if applicable): _____

Address: _____

Telephone: _____ Email: _____

Date of Proposed Visit: _____

Hours/Duration of Proposed Visit: _____

Purpose of Proposed Visit: _____

BH Facility Department(s) Visiting:

Sponsor of Observer: _____

Phone: _____ Email: _____

Department Director(s) decision on application to observe:

Department: _____ Director: _____

Approved or Denied

Reason for decision: _____

Practice Administrator/Executive Director decision on application to observe:

Department: _____ Signature: _____

Approved or Denied

Reason for decision: _____

Administration, or designee decision on application to observe:

Name: _____ Signature: _____

Approved or Denied Date: _____

Reason for decision: _____

OBSERVER CONFIDENTIALITY AGREEMENT

Name: _____

Organizational affiliation (if applicable): _____

Address: _____

Day-time phone: _____ Email: _____

If proposed Observer is a minor, name of the minor's parent: _____

Address, day-time phone number, and email if different from above: _____



I understand that I may see or hear confidential patient information when I visit the BH facility. If I see or hear any information about BH facility patients, I will respect patient confidentiality and I will not share, discuss, or release that information to anyone else without the written permission of the BH facility.

I will not take any pictures while at the BH facility (including with my cell phone) and I will not make any audio or video records while at the BH facility.

I will follow all directions of BH facility personnel while I am a visitor at the BH facility. I will leave a patient care area, or the facility, immediately upon the request of BH facility personnel or physicians.

If I am visiting an operating room, I will not scrub in, enter a sterile field, open sterile products, touch a patient, participate in patient care, or operate equipment associated with a medical procedure.

I will not go anywhere in the BH facility without my Sponsor or an Escort by BH facility personnel.

I understand that if I do not follow these requirements, I may be asked to leave the BH facility and I may not be allowed to return.

*If I am the parent of the Observer, I am responsible for my child following these requirements. I will not allow my child to participate as an Observer unless I believe that my child understands and will follow these requirements.

Signature of Observer Date

*_____
If Observer is a minor, Signature of Parent Date