GENESYS

GRMC MEDICAL STAFF OBSERVER AGREEMENT

This Agreement must be signed by the GRMC credentialed physician to indicate his/her permission and acceptance of responsibility for oversight of the observational encounter by ______________________________ on ____________.

- **This acceptance must be signed by the physician with sufficient time prior to the date observational encounter in for the Medical Education Department to complete its review of all relevant information submitted by the observer.**

Please initial each line and sign below

______ I agree and confirm that this Observer will at all times remain under my direct oversight during this observational encounter at GRMC.

______ I accept responsibility for ensuring that this Observer will be knowledgeable of and in compliance with all GRMC HIPAA and Safety Rules at all times.

______ Further I confirm that this Observer will NOT have any "hands-on" involvement at any time regarding participating in or providing patient care/treatment at GRMC.

______ It is understood that final prior approval for this observational encounter must be provided by the Medical Education Department.

______ I will do nothing to cause such an observational encounter to commence prior to final approval.

______ Further, I accept responsibility for securing patient(s) permission prior to Observer's participation during this encounter.

______________________________ Signature

______________________________ Print Name

______________________________ Date

ACKNOWLEDGEMENT

I hereby affirm that the information provided on this request form and the required accompanied information as noted above is true, complete, and current to the best of my knowledge. Submission of incomplete or false information will result in a denial of this request.

Please initial each and sign below

I understand and agree that (please initial each item below):

______ Approval of this request shall be for observation only under direct oversight of the physician and his/her designated medical staff participants.

______ Such and observational encounter will require the oversight physician to obtain the prior permission from all patients who are observed during this encounter.

______ Any approved observation encounter does not allow student "hands on" involvement at any time, nor does it allow for participating in or providing patient care/treatment at GRMC.

______ No initial period of approved observational encounter will be extended. If an extension is needed a new request will be initiated.

______ I agree to release, indemnify and hold harmless the Hospital, including its present and former trustees, officers, employees and agents from and against any and all losses, expenses, claims, actions, liabilities and judgments which I may have as a result of my participation in this Observation.

______________________________ Student Signature

______________________________ Print Name

______________________________ Date

GENESYS
HEALTH SYSTEM

SECURITY ACKNOWLEDGEMENT AND AGREEMENT FOR STUDENTS/OBSERVERS

As a student/observer at Genesys Health System, I acknowledge that I am responsible for maintaining the security of confidential information including on-line data and hard copied reports. All information relating to employees, the Health System and its finances is legally and ethically confidential information. I understand that all information about the patient, their admission, diagnosis, and treatment is absolutely confidential.
I therefore understand and agree to the following when applicable to my clinical experience:

- I will protect the confidentiality of my computer password and the information used and obtained with said password.
- I agree that I alone will use the password (which represents my electronic signature) that I have been assigned and/or chosen, and I recognize my obligation to access only the information I need to have in order to perform my duties. I will be diligent in maintaining the security of same and report all known or suspected violations or breaches to my instructor or appropriate management.
- I understand that I am responsible for any activity that occurs under my user ID and password, and I will not lend my password to others nor use any other persons' password under any circumstances.
- I understand that any chart that is accessed in the clinical documentation system records the ID and legal signature in the chart Access Log and is available for monitoring. Passwords are inactivated between clinical rotations.
- If I have reason to believe someone may have obtained and/or used my password, I will notify my instructor or appropriate management and request a change in my password if necessary.
- I will not load, download, modify or copy any computer software or information.
- I understand that the careless handling of confidential patient health information (see box below), obtaining, attempting to obtain, possessing or disclosing confidential information without authorization is a serious policy violation, and I further understand that I will be subject to disciplinary action and/or asked to leave the premises.
- I acknowledge that my obligations to adhere to this policy shall continue following the ending of my clinical experience.

Name (please print):______________________________

Signature: ______________________ Program/Internship:______________________

Date:__________________ School/College: ______________________

Protected Health Information or "PHI" or "Patient Information" is defined as information that is: (1) individually identifiable; (2) transmitted or maintained in any form or medium (hard copy, verbal or electronic – including "ePHI"); and (3) relates to (a) a patient's past, present, or future physical or mental health condition, (b) the provision of health care to a patient, or (c) the payment for health care by or on behalf of a patient. PHI includes but is not limited to:

- ◈ Names
- ◈ Zip Codes
- ◈ All Dates
- ◈ Telephone & Fax Numbers
- ◈ E-Mail Addresses
- ◈ Social Security Numbers
- ◈ Any other unique identifying number, characteristic or code
- ◈ Medical Record Number
- ◈ Health Plan Number
- ◈ License Numbers
- ◈ Vehicle Identification Numbers
- ◈ Account Numbers
- ◈ Biometric Identifiers
- ◈ Full Face photos

Please fax form to the Security Administrator at 810-603-8989

GENESYS
REGIONAL MEDICAL CENTER

REQUEST FORM FOR STUDENT OBSERVATION AT GRMC

Please complete this request form in order to ensure timely prior permission to observe with a designated credentialed member of the medical staff of GRMC. No observational encounter can be permitted unless prior permission is granted and it is communicated to the requester. **No permission will be granted on the same day as the observation is to begin or after it has occurred.**

Completion of this request form does NOT in any manner constitute prior approval to observe at GRMC.

Observer: ______________________________ Date: ______________

Mailing Address: ______________________________

E-Mail Address: ______________________________

Observer Contact Phone No.: ______________________________

Medical staff member (only one) who will both participate in and be responsible for direct oversight of you during the requested observational encounter: ______________________________

Date(s) of Requested Observation: ______________________________

Observer's Date of Birth: ______________________________

The following documents are required to be attached and/or completed with this request form to allow processing without delay:

- Immunization Records **(Proof of *negative* TB test – *within the last 12 months* and Pertussis Immunization)**
- Complete HIPPA Requirements (i.e. signed Security Acknowledgement and Agreement #1028426)
- Signed acceptance by physician providing direct oversight of student
- Current Identification (i.e., drivers license, passport, and/or immigration status documentation)