Observership Application

The Observership Program was created for individuals pursuing a career as an MD, DO or PA. The process to apply for an Observership follows:

1. **Observer contacts and receives agreement to Observe from Virtua Clinician BEFORE completing this application. The GME office does not participate in this process.**
   a. **Observership Duration: 14 days - 6 weeks ROTATIONS MUST BE A MINIMUM OF 2 WEEKS**
   b. **Observers cannot shadow in the Virtua Operating Rooms**
2. **Email your resume and Name/Dates of Observation to: GraduateMedicalEducation@virtua.org**
3. **Complete and submit application, including Non Employee Information Confidentiality and Security Agreement and Release and Waiver of Liability, electronically or by fax, including all required documents outlined in the application. Fax: 856-325-3705 Email: GraduateMedicalEducation@virtua.org**

The review process may take at least 4 weeks to complete after the application is received. Incomplete applications may significantly delay the review process.

LOCATION:___VOORHEES ___MEMORIAL____CAMDEN ____BERLIN ____MARLTON
OTHER_____

Beginning Date:_____ ***Ending Date:***_____ ***Duration Requirement: 2-6 Weeks***

Program Director or Physician I will be following is_____

Clinical/Specialty Program:_____

Virtua Department Coordinator (for the clinician)_____

Virtua Coordinator:

Phone Number: _____Fax Number:_____ Email:_____

This Observership is required to pursue my career as a PA, MD, or DO YES or NO(please circle)

Name and address of School you are currently attending:

Name: _____

Address: _____
_____
_____

Name and address of School/Hospital that you will be attending: (if applicable)

Name: _____

Address: _____
_____
_____

Applicant Information:

Name:_____

Address:_____

City:_____ **State:**_____**ZIP:**_____

Gender:_____**Citizenship:**_____

Date of Birth _____ **Social Security Number:**_____

Email Address:_____**Contact #**_____

Emergency Contact Name, Number, and Relation:_____

Licensure: (please attach copy)

Medical Training License Number_____ **Level:**_____

Program/Specialty:_____**Expiration Date:**_____

NJ Permit:_____**Yes/No (attach copy)**

DEA Certificate Number:_____**Date Issued:**_____

National Provider Identifier (NPI):_____

Documents Required and Recommended for **Medical Observer Rotations:**

- □ Attach Copy of Current Curriculum Vitae (required)
- □ Attach copy of the Current Health and Immunizations Requirements (required)
- □ Letter of Good Standing (required)
- □ Attach Copy of ECFMG Certificate (if applicable)
- □ Attach copy of BLS / ACLS / PALS Certificate (if available)
- □ Attach Copy of Current Identification (passport/drivers license)
- □ Attach Copy of Visa (if applicable)
- □ Attach Copy of National Criminal Background Check (required) (can be obtained online) *This takes several weeks to be processed. You must receive clearance prior to starting your hours. The clearance must be current (within 12 months).*
- □ Attach Copy of Drug Screening (required)
- □ Health Insurance (please attach copy of card) (required)
- □ Homeowner's or Renter's Insurance (please attach a copy of Declaration Page) (required) If student is living with parents, their Declaration Page will meet this requirement)
- □ General or Professional Liability Insurance **(Student Mailing Address must match Address listed for Liability Insurance)**
- □ Complete Needlestick and Splash online manual (required) at the bottom of the website below: http://www.virtua.org/about/physicians-center/graduate-medical-education-residencies.aspx

Once the needle stick and splash modules are completed, a confirmation will be automatically sent to the Virtua GME Office.

HEALTH AND IMMUNIZATION REQUIREMENTS

- □ **PPD or TB Survey. If positive result within two years, Chest X-ray report REQUIRED.**
- □ **Measles (Rubelola) Titer – positive result. If not MMR vaccine REQUIRED**
- □ **Mumps Titer – positive result. If not MMR vaccine REQUIRED**
- □ **Rubella Titer – positive result. If not MMR vaccine REQUIRED**
- □ **Varicella Titer – positive result. If not Varicella vaccine REQUIRED**
- □ **Hepatitis B. Titer –positive result. If not HEP B vaccine or signed declination REQUIRED**
- □ **Verification of Flu Shot REQUIRED**
- □ **Verification of Drug Screening REQUIRED**

In making this application I agree to abide by the Bylaws and Rules and Regulations of Virtua and such rules and regulations as may be enacted from time to time. I also understand that I will be considered an observer, there is no hands-on experience and I cannot provide any medical advice or interact with patients. I understand that as an Observer, I cannot go into the Operating Room. I must remain with the clinician listed at the top of this application and cannot follow another physician, unless approved by the GME office. I fully understand that any significant misstatements in or omissions from this application constitute cause for summary dismissal.

I certify by submitting this application that I have read and understood the application. Furthermore, I acknowledge that the information I have provided is correct and complete to the best of my knowledge. I understand that providing false or incomplete information may be cause for disqualification or termination of the observership if appointed.

Signature of Applicant _____Date _____

Please return to: Graduate Medical Education
Tatem-Brown
Attn: Erika Stone-Williams
2225 Evesham Road, Suite 101
Voorhees, NJ 08043

Telephone: 856-325-3737 Fax Number: 856-325-3705 email: estone-williams@virtua.org

Non-Employee Information Confidentiality and Security Agreement

1. During the course of my business relationship with Virtua, I may have access to confidential patient, financial, and corporate-owned information. I agree to abide by all Virtua Policies relating to security, confidentiality, and the use of Virtua information systems.

2. I agree to use only those accounts, which have been authorized for my use. My password is the legal equivalent of my signature. I will not divulge my password nor attempt to learn another person's password.

3. I will not authorize anyone to use my account(s) for any reason. I am responsible for all usage on my accounts. My account usage may be monitored at any time.

4. I will not demonstrate/instruct anyone in the use of Virtua systems unless I am required to do so in my specific job duties.

5. I will use my accounts only for legitimate business purposes. I will not utilize my accounts for conducting unlawful activities or any personal business.

6. I will not copy or remove information from a Virtua system without prior written approval from the Information Services department and the owner of the data, unless the information has been established as shareable and I have been given appropriate access.

7. I will utilize my accounts responsibly. Material that is offensive, fraudulent, harassing, obscene, intimidating, defamatory, or otherwise unlawful may not be distributed electronically or stored on any computer system owned by Virtua.

8. All electronic data created, stored, or transferred through the Virtua network is the property of Virtua. Virtua reserves the right to monitor, access, review, and disclose information contained in any user file without advance notice and/or without my consent.

9. The unauthorized viewing of confidential information; copying of data/files; or wrongful dissemination of such information is a direct violation of Virtua policy and this agreement.

10. If I have reason to believe that the confidentiality of my password is broken, or believe that there has been a misuse of Virtua data, I will contact Virtua Information Services (856-248-6333) immediately.

11. At any time after my employment/business relationship with Virtua has ended, I agree to keep confidential any information to which I had access.

12. If I unlawfully access or misappropriate patient information, I agree to indemnify and hold harmless Virtua, its subsidiaries, affiliates, and its successors and assigns against and from any and all claims, demands, actions, suits, proceedings, costs, expenses, damages, and liabilities, including reasonable attorney's fees arising out of, connected with or resulting from such unlawful use.

13. Violating any term or condition of this agreement may subject me to any or all of the following: voiding/termination of contracts, loss of network access privileges; loss of medical staff privileges; and/or loss of licensure; penalties/and or fines imposed by federal or state law.

By signing below you have read and agree to abide by the regulations contained in this agreement.

Please Print Clearly – ALL FIELDS ARE REQUIRED	
Full name – First, Middle, Last (print):	Signature (black or blue ink, please):
Address:	Cell phone: Pager: E-mail
Name and Address of School:	Have you ever been employed by Virtua? _____YES _____NO If so, at which locations?
Start Date:	At which Virtua locations will you be working?
End Date:	

FORM A
OBSERVERSHIP

Release and Waiver of Liability

I, _<name of Applicant>_, wish to observe the activities of the _<name of Observership> at Virtua Health from START^DATE_____ to _END DATE_____ in furtherance of my educational goals. I understand that I will not be allowed to perform any clinical activities or other work, to include the touching of any patient, documenting on any medical record, and advising care providers or patients.

I further understand that I will be under the supervision of attending physician _<name of physician/s>_____.

I understand I am not to be in any patient care area without supervision.

I understand that if I breach this agreement, it will results in immediate termination of my observership.

I understand that even though I will only be observing activities during my Observership, I may be exposed to certain risk of bodily injury and other dangers, including but not limited to, exposure to blood borne pathogens, biological waste, and dangerous chemicals. I am aware of these risks and voluntarily assume these risks.

For and in consideration of Virtua Health, allowing me to observe the activities of the <name of Observership rotation> to further my educational goals, I hereby release and forever discharge Virtua Health, and its officers, agents, and employees from all claims, demands, rights, and causes of action of whatever kind or nature arising from and by reason of any and all known and unknowns, foreseen and unforeseen bodily and personal injuries, death, or damage to property arising out of my observation activities, including but not limited to, those specific risks enumerated above.

I have read this document carefully and I voluntarily choose to participate in the activities described herein. I hereby certify that I am at least 18 years of age, I am legally competent, and I am signing this document with full knowledge of its significance.

Observer Signature _____ **Date _____**