Observership Application

The Observership Program was created for individuals pursuing a career as an MD, DO or PA. The Program allows individuals the educational experience of shadowing a Virtua Clinician in a patient care setting. The process to apply for an Observership follows:

1. **Observer contacts Virtua Clinician and receives agreement to Observe from Clinician BEFORE completing this application. The GME office does not participate in pairing Observers with Clinicians.**
   a. **Observership Duration: 14 days - 6 weeks ROTATIONS MUST BE A MINIMUM OF 2 WEEKS. The number of shifts per week will vary based on the Clinician's schedule.**
   b. **Observers cannot shadow in the Virtua Operating Rooms**
2. **Email your resume and Name/Dates of Observation to: sritz@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: 856-365-7772 Email: SRitz@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. An Observership may not begin until all paperwork is received and approved by the GME office.

LOCATION: ___VOORHEES ___MEMORIAL____CAMDEN ____BERLIN ____MARLTON
___LADY OF LOURDES ___ OTHER

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

Clinician I will be following is_____

Clinician Phone Number: _____ Clinician Email: _____

Clinical/Specialty Program:_____

Virtua Department Coordinator (for the clinician)_____

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: _____

Date of Birth _____ Social Security Number: _____

Email Address: _____Contact #_____

Emergency Contact Name, Number, and Relation: _____

Have you ever been employed by Virtua? _____ If Yes, list dates and locations: _____

Licensure: (if applicable) (please attach copy)

Medical Training License Number_____ Level: _____

Program/Specialty: _____Expiration Date: _____

NJ Permit: _____Yes/No (attach copy)

DEA Certificate Number (if applicable):_____Date Issued: _____

National Provider Identifier (NPI):_____

Documents Required for Medical Observer Rotations:

□ Attach Copy of Current Curriculum Vitae or resume *(required)*

□ Attach copy of the Current Health and Immunizations Requirements *(required; see requirements below)*

□ Letter of Good Standing *(required – Must be from **current or most recent** school on letterhead with signature)*

□ Attach Copy of ECFMG Certificate *(if applicable)*

□ Attach Copy of Current Government Issued Identification *(passport/driver's license – required)*

□ 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)*

□ Signed copy of Confidentiality and Non-Disclosure Statement *(required)*

□ Signed copy of Release and Waiver of Liability *(required)*

□ General or Professional Liability Insurance *(Student Mailing Address must match Address listed for Liability Insurance – required)*

□ 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 policies and procedures 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 _____

Signature of Parent/Guardian (if student is a minor)_____

Please return to: Sande E. Ritz
Virtua Our Lady of Lourdes Hospital
1600 Haddon Avenue
Camden NJ 08103

Telephone: 856-365-7874 **Fax:** 856-365-7772 **Email:** sritz@virtua.org

CONFIDENTIALITY
AND
NON DISCLOSURE STATEMENT FOR OBSERVERSHIP

I, _____,
Print Full Name
agree that I shall not divulge, disclose, release or make known in any manner or to any extent, any information concerning or relating to patients and patients' treatment, care and/or medical history to which I may observe, obtain or come into possession of from any source whatsoever, including but not limited to Virtua, its agents, servants, employees, representatives and independent contractors. I hereby warrant and represent to Virtua Health, Inc. ("Virtua"), its successors and assigns, that I consider all patient information shall be considered to be confidential and protected health information according to the Health Insurance Portability and Accountability Act of 1996, ("HIPAA") and I agree that anything seen, heard or overheard shall not be divulged by me to anyone. In addition, I shall at all times keep and maintain such information confidential and shall not disclose, disseminate or make available any such information to any person or entity except those Virtua employees directly involved in the health care of the specific patients, without the written consent of Virtua and/or its patients and acknowledge these interests and agree to the conditions as set forth above. At any time after my observership with Virtua has ended, I agree to keep confidential any information to which I had access. 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. Violating any term or condition of this agreement may subject me to any or all of the following: voiding observership relationship or state law.

By signing below you have read and agree to abide by the terms of this agreement.

Observer Signature _____ Date _____

FORM A
OBSERVERSHIP
RELEASE AND WAIVER OF LIABILITY

I, _____ wish to observe the activities of _____ at Virtua Health, Inc. ("Virtua"), at its _____ location, from START DATE_____ to END DATE_____ in furtherance of my educational goals (the "Observership"). 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, or advising care providers or patients.

I understand that I may not observe any patient who has not consented to my presence as an Observer.

I further understand that I will be under the supervision of attending physician _____, at all times.

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

I agree that my participation in the Observership is for educational reasons, and that I am participating in the Observership without expectation of payment or reimbursement. I also understand that I will not be compensated for any time spent observing, nor am I entitled to benefits, including employment insurance benefits upon the termination of this agreement or as a result of the Observership.

I understand that if I breach this agreement, it will result 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.

I UNDERSTAND THAT IF I AM INJURED IN THE COURSE OF THE OBSERVERSHIP, I AM NOT COVERED BY VIRTUA's WORKERS' COMPENSATION PROGRAM. I authorize Virtua to assist me in seeking emergency medical treatment on my behalf in case of injury, accident or illness to me arising from my involvement as an Observer. I understand that I will be responsible for medical costs incurred by such accident, illness or injury. I certify that I carry valid and current health insurance that will cover medical services that might be necessary due to accidents, illnesses or injuries I may face while participating in the Observership. I agree that I will not participate in the Observership should I become uninsured.

For and in consideration of Virtua allowing me to participate in the Observership to further my educational goals, I hereby release and forever discharge Virtua, 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 Observership, 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 _____

Minor Liability Waiver

Parent or Legal Guardian

You are required to read the following information very carefully. Make sure that you understand it fully and sign it before allowing your child to participate in this activity or program.

I, _____, am fully aware that participation in an Observership Program at Virtua Health, Inc., may result in risk of personal injury to my child, _____. I hereby agree to release and hold harmless Virtua Health, Inc., its officers, employees, committees and boards, from and against all liability, loss, damages, claims, or actions (including costs and attorney's fees) for bodily injury to the extent permissible by law.

I understand that my child will not be allowed to perform any clinical activities or other work, to include the touching of any patient, documenting on any medical record, or advising care providers or patients.

I understand that my child will not be in any patient care area without supervision.

I understand that even though my child will only be observing activities during his/her Observership, he/she 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 on behalf of my child.

I UNDERSTAND THAT IF MY CHILD IS INJURED IN THE COURSE OF THE OBSERVERSHIP, HE/SHE IS NOT COVERED BY VIRTUA's WORKERS' COMPENSATION PROGRAM. I authorize Virtua to assist my child in seeking emergency medical treatment on his/her behalf in case of injury, accident or illness to my child arising from my involvement as an Observer. I understand that I will be responsible for medical costs incurred by such accident, illness or injury. I certify that I carry valid and current health insurance that will cover medical services that might be necessary due to accidents, illnesses or injuries my child may face while participating in the Observership. I agree that my child will not be permitted to participate in the Observership should I become uninsured.
For and in consideration of Virtua allowing my child to participate in the Observership to further his/her educational goals, I hereby release and forever discharge Virtua, 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 child's Observership, including but not limited to, those specific risks enumerated above.

I have read this document carefully and I voluntarily choose to allow my child to participate in the activities described herein. I hereby certify that I have the legal authority to sign on behalf of my child, and I am signing this document with full knowledge of its significance.

Parent Signature_____ Date_____