Observership Application

LOCATION: VMG Office

Applicant Information

Name:

Email Address: Phone #:

Emergency Contact Name, Number, and Relation:

Have you ever been employed by Virtua: No

Current level of education: Medical Student (MD/DC

If a medical student, are you enrolled in a medical school in the continental U.S.? No

1. Observership Start Date: End Date:

Clinician Information

Clinician Name: Clinician Email:

Clinician Phone Number:

Clinical/Specialty Program:

Institution/School Information

Name and address of School you are currently attending:

_____

Address: _____

_____

_____

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 and I cannot provide any medical advice to patients. I must remain with the clinician listed at the top of this application and cannot follow another physician, unless approved by the UME office. I also understand that any observership at Virtua will be limited to, but is not guaranteed to include, (i)

observation of operative procedures, (ii) the taking of histories, (iii) the performance of physical examinations (high school and college students are excluded from performing physical examinations), and (iv) the participation in patient rounds and organized patient care activities of the supervising physician; provided, however, that I may not participate in any such activities without the prior consent of the patient and either the supervising physician identified in this application or another physician approved by the GME office. I understand that the role of an observer in any interaction with a patient is to gather information and that I may not provide the patient with any information or opinion regarding such patient's physical condition, diagnosis, or clinical care. 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: Undergraduate Medical Education
2225 E Evesham Road
Voorhees NJ 08043

Telephone: 856-325-3737 **Fax:** 856-325-3705
Email: UME@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 _____

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 _____