APPLICATION TO OBSERVE AT
TALLAHASSEE MEMORIAL HEALTHCARE

TMH is Presently Unable to Provide or Assist in Finding Observation Sponsors

APPLICANT STATUS (Check all that apply)				
☐ Undergraduate Student	☐ Graduate Student	☐ Medical Student	☐ Pre-Med Student	☐ Resident
☐ Licensed Independent Practitioner	☐ Allied Health Student	☐ TMH Colleague	☐ Other _____	

APPLICANT INFORMATION		
Last Name	First Name	M.I.
Street Address		Apartment/Unit #
City	State	Zip Code
Are you at least 16 years old? ☐ Y ☐ N	Are you at least 18 years old? ☐ Y ☐ N	*If under age 18, a parent or legal guardian must also sign the Disclaimer below.*
If Student, Name of School/Program		Graduation Date
Email Address		Phone Number
Emergency Contact	Relationship	Phone Number

REASON FOR OBSERVATION REQUEST (Please explain why you are interested in this observation opportunity.)

APPLICANT DISCLAIMER AND SIGNATURE

By signing this application,

- I understand I am requesting consideration for an observation at Tallahassee Memorial HealthCare.
- I understand that this observation will be hands-off and I will not be permitted to engage in patient care.
- I understand that this observation will be at the patient's discretion and that if a patient is not comfortable with my presence as an observer, I will be asked to leave the patient care area.
- At any time, I will not be asked or allowed to answer specific questions about a patient's care or treatment, or otherwise provide medical or professional opinions.
- I understand that through my sponsor, I will be expected to follow all TMH policies, procedures, rules, and regulations, including those pertaining to HIPAA, patient confidentiality, infection control, and safety.
- I agree to follow the directives of my TMH sponsor and will remain with my sponsor at all times.
- I understand that I am on TMH property at my own risk and insurance coverage, that I will not be indemnified/insured by TMH.
- I understand that if I breach any policy, procedure, rule, or regulation, my permission to act as an observer will be withdrawn and I may be asked to leave immediately.
- If approved, I will wear my observation badge at all times while at TMH and return it to Human Resources at the conclusion of the approved observation.
- I certify that my answers on this application are true and to the best of my knowledge. If this application is approved, I understand that I am responsible for completing all necessary clearance requirements prior to beginning my observation.

APPLICANT SIGNATURE	**DATE**
PARENT/LEGAL GUARDIAN SIGNATURE (If Applicable)	**DATE**

FOR COMPLETION BY TMH SPONSOR		
Last Name	First Name	☐ MD ☐ RN ☐ Other _____
Practice Name, if applicable		
Email Address	Phone Number	
Requested Observation Duration: Start Date	End Date	
TMH Departments of Observation		

TMH SPONSOR STATEMENT AND SIGNATURE

As a TMH employee and/or member of the Medical Staff with appropriate privileges for procedures, I endorse this applicant to be approved for an observation at Tallahassee Memorial HealthCare. This applicant will be under my full supervision for the duration of the observation. I have received this application and by signing below, I agree to the following:

- I agree to personally oversee and supervise this individual for the approved duration of this observation.
- I will ensure the applicant will abide by TMH policies, procedures, rules, and regulations including those pertaining to HIPAA, patient confidentiality, infection control, and safety.
- I understand that the applicant will only be permitted to view patient care with the consent of the patient and I will identify the applicant to all patients as an observer.
- I agree that the applicant will have no direct patient contact or provide any type of medical care.
- I will ensure the applicant will wear his/her observer identification badge at all times while at TMH.
- I will ensure the applicant does not enter isolation rooms and will not participate in an observation when he/she is sick, has a fever, or has been exposed to a contagious disease.
- I will report any violation of TMH policies, procedures, rules and regulations by the applicant to Human Resources.

SPONSOR SIGNATURE	**DATE**

Please submit this completed form to TMH Human Resources:

Academic Liaison
1623 Medical Drive, Ste. 1
Tallahassee, FL 32308
Phone: (850) 431-5786
Fax: (850) 431-6555

FOR INTERNAL USE ONLY BY HUMAN RESOURCES:

TMH DEPARTMENTAL APPROVAL

Department	**Approver**	**Position**	**Date**
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Application Received: _____ Clearance Requirements Sent: _____ HR Initials: _____