

OBSERVATION APPLICATION TALLAHASSEE MEMORIAL HEALTHCARE

(DO NOT COMPLETE IF YOU ARE A CURRENT TMH EMPLOYEE PLEASE REFER TO SPARK)

APPLICANT STATUS (Check all that apply)				
<input type="checkbox"/> Undergraduate Student	<input type="checkbox"/> Graduate Student	<input type="checkbox"/> Medical Student	<input type="checkbox"/> Pre-Med Student	<input type="checkbox"/> Resident
<input type="checkbox"/> Licensed Independent Practitioner	<input type="checkbox"/> Allied Health Student	<input type="checkbox"/> Former TMH Colleague N# _____	<input type="checkbox"/> Other:	
APPLICANT INFORMATION				
Last Name:		First Name:		M.I.:
Street Address:			Apt. / Unit#:	
City:		State:	Zip Code:	
Are you at least 16 years old? <input type="checkbox"/> Y <input type="checkbox"/> N		Are you at least 18 years old? <input type="checkbox"/> Y <input type="checkbox"/> N		<i>If under age 18, a parent or legal guardian must also sign the Disclaimer below.</i>
Name of School/Program (STUDENTS ONLY):			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				
<p>By signing this application,</p> <ul style="list-style-type: none"> 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 I understand that if I breach any policy, procedure, rule, or regulation, my permission to act as an observer will be withdrawn and I may be asked to leave immediately.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. I understand that as an observer, I risk possible exposure infectious diseases, including but not limited to COVID-19, which may lead to serious illness or death. I knowingly and freely assume all risks related to exposure to infectious diseases, including but not limited to COVID-19, and I hereby release and discharge TMH and its employees, officers, directors, and agents, from any claim whatsoever which I or my representatives or heirs may have arising out of my exposure to infectious diseases, including but not limited to COVID-19, as an observer on TMH property. 				
APPLICANT SIGNATURE:			DATE:	
PARENT/LEGAL GUARDIAN SIGNATURE: (if applicable)			DATE:	

