

OBSERVATION APPLICATION TALLAHASSEE MEMORIAL HEALTHCARE

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

APPLICANT STATUS (Ch	ock all that annly)							
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Undergraduate Student	Graduate Student	L	Medical Student		Pre-Med Studen		Resident	
Licensed Independent Practitioner	☐ Allied Health Stud	lent L	Former TMH Colle N#	ague		Other:		
APPLICANT INFORMATI	ON		1411					
Last Name:		First Na	ame:				M.I.:	
Street Address:					Ap	t. / Unit#	 :	
City:			State:			Zip Cod	de:	
Are you at least 16 years o	old?	Are you	ı at least 18 years o	ld?	Υ _] N	under age 18, a parent or legal guardian must also sign the Disclaimer below.	
Name of School/Program (STUDENTS ONLY):			Gra	aduatior	n Date:		
Email Address:						Phone	Number:	
Emergency Contact:			Relationship:			Phone Number:		
REASON FOR OBSERVAT	TION REQUEST (Plea	ase explair	n why you are interest	ted in th	is observ	ation opp	portunity.)	
APPLICANT DISCLAIMER	R 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 I understand that if I breach any policy, procedure, rule, or regulation, my permission to act as an observer will be withdrawn and I may be asked to leave immediately.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. 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								
APPLICANT SIGNATURE:						DATE:		
PARENT/LEGAL GUARDIA (if applicable)	AN SIGNATURE:					DATE:		

APPLICANT INFORMATION							
Last Name:	First Name:	First Name:					
FOR COMPLETION BY TMH SPONSOR							
Last Name:	First Name:	I □ Other:					
Practice Name (if applicable)							
Email Address:			Phone Number:				
Requested Observation Duration: START DATE: END DATE:							
TMH Department(s) 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:					
TMH DEPARTMENT APPROVAL							

TMH DEPARTMENT APPROVAL							
DEPT LEADER	PRINT	POSITION:	DATE:				
SIGNATURE:	NAME:	POSITION:					

 $\label{thm:please submit the completed Observation Application to: \\$

The Office of the Academic, via email at:

Academic.info@tmh.org

PLEASE DO NOT FAX FORM

For questions, please contact the Academic Liaison at (850) 431-5786 or email.