

TidalHealth Observation Only Agreement

Are you employed by TidalHealth? Yes No

Observer: _____ Date(s) of observation: _____

Purpose of evaluation: _____

Area(s) of observation: Patient care areas including these specific areas (check all that apply):

- Surgical Services Emergency Department Pediatrics Special Care Nursery
 Mother / Baby Labor and Delivery Other: _____

Observer agrees the following Behavioral Health areas are not included in observation experience. (Station 3/7 ED, Adult PHP, Outpatient Crisis Center, Adolescent Behavioral Unit, 3 South). Conditional individual exceptions will be reviewed by Workforce Development Manager based on career focus and desired observation experience.

Referring agency/school/hospital: _____

Physician/PA/NP/CRNA/CNM/care area/dept. providing supervision: _____

This completed form is to be submitted to sonon.cox@tidalhealth.org or lori.lee@tidalhealth.org at least three business days prior to scheduled observation.

1. The observer shall participate in an "observation only" program at TidalHealth in the area(s) specified in this agreement.
2. The observer can only "observe" the care that is provided by the physician/physician group, physician assistant, nurse practitioner, certified nurse anesthetist or certified nurse-midwife that participates in the observation status. For those assigned to a specific department, the observer must be with a staff person at all times.
3. The observer shall not participate in the delivery of health care services in any way but shall continue his/her activities solely to observations.
4. During the term of this agreement, the individual or department responsible for supervision and the referring agency, if applicable, shall be responsible for all actions of the observer.
5. Observer agrees to abide by all the rules and regulations of TidalHealth during the course of this agreement, including without limitation, protection of the privacy of all TidalHealth patients. **Confidentiality must be maintained at all times, both on and off any TidalHealth properties.**
6. If the observer is under the age of 18, a parent or guardian must read and sign this form attesting to their understanding of the above guidelines.
7. Observer shall meet the minimum requirement of being a having completed their freshman year in high school.
8. Observer will attach a copy of their driver's license **or** other government issued photo ID, student ID (if applicable), proof of COVID vaccine or signed COVID declination form, and current flu vaccine. (October 1 — April 30)

Observer

Signature: _____ Date: _____

Address: _____

Telephone: _____ Email address: _____

Parent or guardian (if observer is under the age of 18):

Signature: _____ Date: _____

Address: _____

Telephone: _____

** Verification of completion of Surgical Services orientation program (if required)

Signature: _____ Date: _____

Perioperative educator: Susan Lynch

****Provider responsible for supervision:** (required when provider is an APP i.e., physician assistant, nurse practitioner, certified nurse anesthetist or certified nurse-midwife)

Provider name: _____ Signature/Date: _____ / _____

Supervising physician: _____ Signature/Date: _____ / _____