Appendix A

UC Health Observation Request Form Return all documents to:
Department of Education: education@uchealth.com
Phone: 513-585-5320

Name _____ Date of birth _____

Email _____ Phone _____

Number of Days Observing: _____ Reason for Visit: _____

Requested Start Date(s): _____ * End Date: _____

Observations are limited to 30 days. Badge card will indicate expiration date above or 30 days after issue, whichever is shorter. Extensions after 30 days require new badge card authorization from Vice President of Education.

Sponsoring Staff Member: _____

Contact Person Name: _____ Phone / E-Mail: _____

All activities of the observer are to be performed in conjunction or in consultation with the sponsor or in conjunction or in consultation with the sponsor's designee.

Unit(s) where Observation will occur:

- Hospital Unit or Procedure Area : _____
- Hospital Clinic: _____
- Location: _____

I approve observation of this applicant for the time period stated above.

Signature of Responsible Manager _____ Printed Name _____ Date _____

The following are required and must be attached:
Attach a copy of the following:

- Observation Request Form (Appendix A)
- TB Attestation/TB test results within previous 12 months
- Consent and Release (Sponsoring Staff) (Appendix B)
- Consent and Release (Observer) (Appendix C)
- Signed Confidentiality Statement (Appendix D)
- Consent and Release (Parent or Legal Guardian) (Appendix E)
- Copy of Government Issued Photo ID/Passport
- Evidence of seasonal flu vaccine if observation request between October (10/01) and March (3/31)

Approved: _____ _____

Signature of UC Health Department of Education Date

Department Name for Badge: _____

UC Health

Appendix B

Consent and Release (Observer)

In requesting approval for observation of patient care at _____, I expressly accept these conditions during the processing and consideration of my request, and throughout the observation period.

1. I understand and agree that I have the burden of producing adequate information for proper evaluation of my qualifications or any other matter that might directly or indirectly have an effect on patient care or the orderly operation of the facility to which I am seeking access.

2. I certify I'm free from communicable diseases, and that within 24 hours of a request by UC Health personnel I can provide evidence that I am free of active tuberculosis (as shown by PPD skin testing or chest X-ray), immune from hepatitis B (or declined in writing to be immunized against hepatitis B), immunized against influenza (annually), and is either immune from or has been immunized against rubella, mumps, measles, and varicella (chicken pox).

3. I have read and understand the attached safety material regarding Infection Control, Universal Precautions, Blood- and Air-Borne Illness, Personal Protective Equipment, Radiation Safety, and Life Safety. I agree to abide by these and all other policies of the facility to which I am seeking access.

4. I understand and agree to the requirements in the UC Health **CONFIDENTIALITY AND DATA SECURITY AGREEMENT for Contractors and Non-employees. (Appendix D)**

5. I understand that additional observation to the unit or area may be required by the hospital unit manager. I agree to meet any additional requirements as needed.

6. I understand that the management of the hospital has the right to revoke permission for observation at any time, and agree that I will immediately leave the Patient Care Area if requested to do so.

7. I hereby release UC Health, LLC, University of Cincinnati Medical Center, LLC, West Chester Hospital, LLC, Daniel Drake Center for Post-Acute Care, LLC, University of Cincinnati Physicians Company, LLC, Drake Development, LLC (doing business as Bridgeway Pointe), their respective directors, officers, agents and employees, and any third parties (including but not limited to all individuals, government agencies, organizations, associations, partnerships, corporations, limited liability companies or other entities, whether hospitals, insurers, or health care facilities) from any and all civil liability that may arise from my activity at the facility to which I am seeking access during my observation period. This includes but is not limited to any liability for exposure to infectious agents or development of any illness that might be attributable to my activity at the facility to which I am seeking access.

8. I hereby represent that I have voluntarily signed this Consent and Release; and, that I have no questions regarding the content herein.

_____ _____

Signature **Date**

_____ _____

Printed Name **Date of Birth**

UC Health

Appendix C

Consent and Release (Sponsoring Staff)

Visiting Observer: _____

Date of Visit: _____

Facility and Location where Observation will take place: _____

In agreeing to sponsorship of observation of patient care by non-employees of UC Health or its affiliates, I expressly accept these conditions throughout the period of the visitor's observation.

1. I agree that I have the primary responsibility of supervision of the observer's activities during the duration of the visit. I agree to abide by all hospital and departmental policies and procedures related to observation of patient care.

2. I agree to obtain informed consent of the patient to include agreement to observation by the visitor.

3. I understand that requests from individuals under the age of 18 will be evaluated by the manager of the area to be observed on a case-by-case basis. Parent/Guardian consent must be obtained.

4. I understand that individuals who are observers are not permitted to scrub for operative procedures, or operate equipment or otherwise participate in patient care.

5. I hereby release UC Health, LLC, University of Cincinnati Medical Center, LLC, West Chester Hospital, LLC, Daniel Drake Center for Post-Acute Care, LLC, University of Cincinnati Physicians Company, LLC, Drake Development, LLC (doing business as Bridgeway Pointe), their respective directors, officers, agents and employees, and any third parties (including but not limited to all individuals, government agencies, organizations, associations, partnerships, corporations, limited liability companies or other entities, whether hospitals, insurers, or health care facilities) from any and all civil liability that may arise from my sponsorship of the visitor listed above. This includes but is not limited to any liability for exposure to infectious agents or development of any illness that might be attributable to the activity of the visitor listed above.

_____ _____

Signature of Sponsoring Staff **Date**

_____

Printed Name

CONFIDENTIALITY AND DATA SECUITY AGREEMENT
Contractors or Non-employees

PLEASE READ THE ENTIRE AGREEMENT.

As a contractor or non-employee of UC Health, you have a legal obligation to protect the rights of patients as defined under the Health Insurance Portability and Accountability Act (HIPAA). You are required to keep confidential Protected Health Information and other vital data you may access during the course of your work for or associated with UC Health. The following defines this information and provides a series of statements you must review to fully understand your obligations, as well as appropriate use of the Internet at UC Health.

Description of Protected Health Information (PHI)
PHI includes patient identifiable health information, medical records and financial or billing information relating to a patient's past, present or future mental or physical condition; or past, present or future provision of healthcare; or past, present or future payment for provision of healthcare. It may be in oral, paper or electronic form and contains any of the following identifiers that may be used to identify the patient:

- Name
- Place of residency (including street address, county, city, zip code)
- Telephone/fax numbers
- E-mail addresses
- Social Security Number
- Medical Record Number
- Health plan beneficiary number
- Account numbers
- Birth date, admission date, discharge date, date of death, all ages over 89
- Certificate/license numbers
- Vehicle identifiers and serial numbers including license numbers
- Device identifiers/serial numbers
- Web Universal Resource Locators (URLs, i.e. web page identifiers), Internet Protocol (IP address number)
- Biometric identifiers (voice, finger prints)
- Full face photo image
- Any other unique identifying number, characteristic, or code

<u>Description of Other Confidential Information</u>
Confidential information also includes, but is not limited to, combined clinical data, employee records, processes, marketing plans or techniques, product or service plans, strategies, forecasts, customer/patient lists, supplier lists, discoveries, ideas, pricing policies and financial information. This confidential information can be obtained through hearing it, seeing it, viewing the paper or electronic medical record or accessing it in a hospital computer system.

UC Health

Requirements of All UC Health Contractors or Non-Employees Regarding PHI and Confidential Information

The services provided by UC Health and corresponding PHI are highly confidential and must not be released or discussed with unauthorized persons. There are both Federal and State Laws which safeguard the privacy and confidentiality of PHI and other confidential information from unauthorized access, use or disclosure.

Contractor or Non-Employee Agreements Regarding Use of PHI, Confidential Information and the Internet

- I agree to abide by UC Health HIPAA policies on privacy and confidentiality of PHI.
- I agree to access, use or disclose only PHI for which I am authorized through my work for or associated with UC Health and as complies with UC Health HIPAA policies. I agree not to invade patient privacy by examining PHI or data for inappropriate review.
- I agree not to discuss PHI in unauthorized areas such as hallways, elevators and cafeterias, where it could be overheard.
- I agree not to make unauthorized disclosures, copies or transmissions of PHI in any form including electronic transfer of PHI to personal devices.
- I understand that any access to PHI for research purposes requires proper documentation and approval according to HIPAA policies.
- If given a system password(s) to use, I agree to keep it (them) confidential and not share it (them) with any individual or allow any individual to access information through my password(s). I understand that giving a password to an unauthorized individual may result in disciplinary action up to and including contract or account access termination.
- I understand my password(s) may identify information that I have accessed, which may be monitored and audited
- I understand my password(s) may be changed periodically to help maintain the security of UC Health.
- I understand that I must safeguard data at all times – during its origin, entry, processing, distribution, storage and disposal. This includes data in electronic, paper, film, video or other forms.
- I understand that I must safeguard data from unauthorized access (accidental or intentional), modification, destruction or disclosure.
- I understand that data used in business and clinical operations is an asset of UC Health.
- I understand that e-mail is the property of UC Health and its member institutions and may be monitored. I further understand that I should have no reasonable expectation of privacy when using UC Health e-mail or Internet.
- I understand that, should I have access to the Internet, it is provided by UC Health to assist in completion of work assignments (i.e. patient care, research, education). I understand that this access should be considered an extension of my work environment.
- I understand that the use of unlicensed or unapproved software constitutes a serious risk to UC Health operations.
- I understand that upon my contract termination or end of work with UC Health, my ability to access UC Health information will end. I agree that I will not attempt to access

the systems or disclose any confidential information and/or PHI to any person or entity at that time.

- I understand at the termination of my contract or end of work with UC Health, I will return any confidential information including PHI that is in my possession, to UC Health.
- I understand I must continue to honor all of the obligations mentioned above after termination of my contract or end of work with UC Health.
- I understand that UC Health reserves the right to immediately terminate my access to electronic medical records if there is inappropriate access to PHI.
- I understand that unauthorized access, use or disclosure may have serious legal repercussion for me and/or my employer.
- I understand unauthorized access, use or disclosure of PHI may subject me and/or UC Health to Federal and State fines and penalties
- I understand that access to PHI for illegal purposes will subject me to prosecution to the full extent of the law.

I have read this document and understand that my signature constitutes my acceptance of the terms of this agreement and that a violation of it can result in disciplinary action, up to and including termination of my contract or relationship with UC Health and/or termination of my access to UC Health electronic systems including the electronic medical record. I also recognize that by signing this agreement, there may be serious legal, ethical and personal consequences for violating its terms.

Name (Print)	Organization (Print)
Signature	Date of Signature
Date of Submission or Receipt	