St Luke's
UNIVERSITY HEALTH NETWORK

# Short-term Observer Registration Form

*(1 – 3 day experience)*

**Please complete page 1 & 2**

| | | | |
|---|---|---|---|
| First Name: | MI | Last Name: | Gender: |
| Address Line 1: | | | |
| Street Address Line 2: | | | |
| City: | State: | Zip: | |
| Home Phone: | Cell Phone: | | |
| E-mail: | | | |

**Observership Information**

| | | |
|---|---|---|
| Placement/Department: | Start Date: | End Date: |
| School (if applicable): | St. Luke's Supervisor: | |

**Emergency Contact Information**

| | | |
|---|---|---|
| First Name: | Last Name: | Relationship: |
| Address: | | |
| City: | State: | Zip: |
| Home Phone: | Work or Cell Phone: | |

**ASSUMPTION OF RISK, RELEASE AND INDEMNIFICATION AGREEMENT**

I wish to participate in an Observation Experience at St. Luke's University Health Network. As part of this experience, I may be exposed to a variety of graphic depictions of individuals or body parts, medical tests or procedures, etc.

In consideration of my participation in the Observation Experience, and intending to be legally bound hereby, I, for myself, my heirs, executors, administrators and assigns, hereby forever waive, release and discharge St. Luke's, its officers, trustees, employees, agents, volunteers, representatives, parent, subsidiaries, affiliates, individually and as representatives of such organization, from any and all liability, rights, demands, claims for damages and cause for suit or legal action, attorneys' fees, medical, emergency or other expenses, known or unknown, real or potential, including but not limited to claims for death, personal injury and/or property loss, that I may have arising out of or resulting from my participation in the aforesaid activity.

I understand I will not be given a letter of reference/recommendation. Hours may be provided by the sponsoring department manager on letterhead, upon request.

I attest and verify that: (a) I have full knowledge of the risk involved in my participation of this activity; (b) I assume any and all risk and will pay my own medical, emergency and other expenses in the event of an accident, illness or other incapacity, regardless of whether I have specifically authorized such expense; and (c) that I am physically and efficiently conditioned to participate in this activity after consulting with my own health care provider.

Participant Signature _____ Printed Name_____

Parent/Legal Guardian Signature _____ Printed Name_____

Date: _____

**Continue to page 2**

**ST. LUKE'S UNIVERSITY HEALTH NETWORK**
**OBSERVER/VENDOR MEMORANDUM OF UNDERSTANDING**

I, _____(name of observer/vendor representative), understand and agree that all information I encounter during my experience at St. Luke's University Health Network and its subsidiaries and affiliates (hereinafter collectively referred to as "St. Luke's") will remain strictly confidential. This includes patient protected health information ("PHI"), whether verbal, written or electronic, and includes the fact that an individual is a patient and any information regarding the patient or their condition, whether or not contained in the patient's medical or billing record.

I also understand that I may be provided or may have access to information, records or other material which may contain personal, private or confidential information of or about individuals or of or about St. Luke's, the disclosure of which is prohibited by applicable law and/or St. Luke's policies. This information may include, but is not limited to, information and communications regarding the plans, patients, services, markets, developments, strategies, or practices of St. Luke's, and other information that is confidential or proprietary to St. Luke's that St. Luke's wishes to remain private and confidential (collectively "Confidential Information").

I agree that:

- I will not disclose, either directly or inadvertently, any PHI or Confidential Information, or discuss any such information whether inside or outside of St. Luke's, or use any such information for my benefit or the benefit of any third party.
- I will take all necessary steps to maintain the privacy and confidentiality of the Confidential Information and the PHI both during and after the conclusion of my experience at St. Luke's.
- I will adhere to any additional or more specific requirement relating to privacy and confidentiality that may be imposed by any applicable law, contract, or policy.
- I will not take any photos or make any recording of St. Luke's or any patient or post on any social media platform or publish in any manner any photos, recordings, or comments about St. Luke's, any patient, or my experience.

Further, in addition to the confidentiality principles described above, I recognize that I am not an employee or agent of St. Luke's or a member of its workforce and I will not represent myself as such or as a practicing clinician during my experience at St. Luke's. If a patient or family member asks me any question(s) of a clinical nature, I will immediately redirect the inquiry to St. Luke's professional staff for handling. I further agree not to engage or attempt to engage in any clinical and/or professional activity for, on behalf of or with any patient(s) or family member(s), arising out of or relating in any way to my experience at St. Luke's. St. Luke's may take any action it deems necessary to protect its patients and facilities, including terminating an observation experience.

I recognize that St. Luke's has rules of conduct, behavior, and personal health standards and I will be expected to conform to those rules that apply to my experience. I also agree to comply with St. Luke's ethics policies that would also apply to me in my role, and I agree to sign such other forms as St. Luke's may require in furtherance of its policies and/or standards.

I agree not to visit any St. Luke's facility if I have any active signs of infection, including sore throat, runny nose, cough, muscle pain, fever, blood shot eyes, or rash.

Finally, I understand that (a) any use or disclosure of the Confidential Information or PHI either during or after my experience with St. Luke's concludes may result in corrective action and may also subject me to any and all applicable criminal or civil penalties, and (b) St. Luke's will terminate my experience immediately if it determines in its sole discretion that I have violated this Memorandum or any other applicable policy or expectation.

**Signatures below indicate understanding and acceptance of the contents of this Memorandum of Understanding.**

_____

Signature (Observer/Vendor) Date