UNIVERSITY HOSPITAL
Newark, New Jersey

OBSERVER APPLICATION

Please fill out completely. Incomplete forms cannot be processed

OBSERVER INFORMATION			
Name:		Degree:	Day Phone:
Address:			Evening Phone:
City:	State:	Zip:	Email:
Medical area of interest:			
School (*if applicable*):			Grade level:
I am 18 years of age or older ☐ Yes DOB: _____			
Current Job Title (*if applicable*):			
Company Name:			Phone:
Have you been convicted of a felony? ☐ Yes ☐ No Have you ever had a license revoked or denied? ☐ Yes ☐ No			
☐ I have made specific arrangements with a University Hospital physician and have been accepted for an observational experience.			
Physician Name:			Title:
Dept/Unit:			Phone:
Coordinator's Contact Information (*if applicable*)			
Name:			
Email:			Phone:

Reason for requesting observational activities:

☐ I am a medical professional (e.g. physician, APN, PA) seeking additional experience.

☐ I am a medical professional (e.g. physician, APN, PA) seeking to observe at the invitation of _____ for the purpose of mutual sharing of clinical, teaching, and/or research.

☐ I am employed by a commercial vendor to provide specific training to practitioners or University Hospital staff.

☐ I am a United States medical school student who seeks observation hours or shadowing experience.

☐ Other: Please explain in detail.

Date(s) of Observational Activity**: _____

****HIPAA training is required and must be provided to the Chief Medical Officer prior to the start of the observation period. Failure to comply may result in rescission of observation privileges.**

**** Pre-medical students may request up to three (3) calendar days, regardless of length of session per calendar year.**

I understand the observational experience provided by University Hospital is done as a public service in the interest of medical education. I understand that all information about patients, whether it is medical or personal, is absolutely confidential. I have read and signed the Statement and Agreement regarding University Hospital Information.

I understand that as an observer, regardless of background and training, I may not perform any medical procedure. I will not have direct contact with patients, or have unsupervised access to patients. I agree to the following statements:

- My required immunizations are current and I have attached my immunization records.
- I have not had any exposure to measles, rubella or chickenpox in the last 30 days.
- I have attached evidence of Tuberculosis screening within the past one (1) year (Attach PPD)

I agree to hold harmless University Hospital from any present and future liability and/or damages for injury arising from or growing out of this observational experience. I fully understand that this application is for observational privileges and I am not applying for medical staff appointment or permanent clinical privileges.

Signature of Applicant:	*Date:*

Supervising Medical Staff Attestation

I know this applicant and based on my knowledge of this applicant, his/her training, current competence, and health status as it affects performance, I attest that this person is physically and mentally competent to observe in the University Hospital clinics or other University Hospital areas, and is observing for the purpose of medical education, research or training. I attest that the purpose of this observational experience is not solely for the benefit of a commercial vendor. I also attest that I will receive the permission of all patient(s) prior to observation for this person to observe and will introduce the observer to any patients subject to observation.

The person observing will be in my presence at all times.

Signature:	*Date:*
Supervising Physician	
Signature:	*Date:*
Department Service Chief *(Required if Observation period greater than 30 calendar days)*	

Observation Privileges are Granted:

Signature:	*Date:*
University Hospital Chief Medical Officer	

All observers at University Hospital must provide proof of current immunizations including PPD and Influenza Vaccination.
Questions about immunization should be directed to Employee Health Services: 973-972-3066

Return this completed form to:
University Hospital Medical Staff Affairs and Education
Phone: (973)972-7300
Email: nurseaq@uhnj.org
Fax: 973-972-2848