

# Observer Form

Personal Information		
Name (First, Middle, Last)		Date of Birth
Street Address		
City, State, Zip Code, Country		Email Address
Daytime Phone	Evening Phone	
Emergency Contact Name	Relationship	Phone
Professional Information (for licensed individuals only)		
Wisconsin Licensure, if applicable Number:                      Exp Date:		Home State Licensure, if applicable State:                      Number:                      Exp Date:
Licensed in Home Country as		Type of Visa, if applicable
Purpose of Visit		
Observation for school requirement (List School / Program) _____ Observation with educational lecture                      Potential Employment at Froedtert Health Professional Development – observe how care is provided at a Froedtert Health Affiliate Career Exploration Participation in education rounds                      Other: _____		
Froedtert Health Facility – check one <input checked="" type="checkbox"/> Froedtert Hospital <input type="checkbox"/> Community Memorial Hospital <input type="checkbox"/> St. Joseph's Hospital <input type="checkbox"/> F&MCW Community Physicians; clinic location _____		
Department/Area Requested for Observation    EMERGENCY		
Date/Time of Visit                      TBD		
List the activities and/or educational objectives for this observation    Shadow EM Faculty		
Health Requirements		
	DOCUMENTATION (Observer please indicate approximate dates of TB screen and immunizations).	
1. A negative TB (tuberculosis) skin test or negative chest x-ray done within the past 12 months.		
2. <b>If born prior to January 1, 1957:</b> Proof of 1 MMR vaccine <b>or</b> a positive Rubella titer.		
3. <b>If born on or after January 1, 1957:</b> Proof of 2 MMR vaccines or a positive Rubella titer <b>and</b> a positive Rubella (measles) titer.		
Observer Signature		
I certify that the information in this document and any attached documents is true, correct, and complete. I understand and agree that any misrepresentation, misstatement, or omission from this application, if discovered after Observer status has been awarded to me, may lead to termination of my participation in the Observer Experience.		
Printed Name of Observer	Date	
Signature of Observer	Academic Institution / Year in school (if applicable)	
If under 18, signature of parent or legal guardian and relationship	Date	

Complete this form prior to the observation.



# Observer Agreement

Observer Name:	Department: EMERGENCY
Date: TBD	Start Time: TBD End Time:

The Froedtert Health Affiliate has agreed to allow the undersigned Observer to observe patient care after meeting the established requirements. In consideration of the Observer being allowed the opportunity to observe at the Froedtert Health Affiliate, the undersigned Observer hereby agrees to the following:

**Confidentiality** - The Observer agrees that any information or knowledge acquired or received during the course of the observation, including but not limited to patient care information and information contained in patient care records, shall be treated as confidential and shall not, unless required by law or otherwise specifically permitted by the Froedtert Health Affiliate, be disclosed or used during or after the Observer’s observation at the Froedtert Health Affiliate without the prior written consent of the Froedtert Health Affiliate.

**Release/Indemnification** - The Observer agrees to and hereby does release, indemnify and hold harmless the Froedtert Health Affiliate, its members, directors, officers, employees and representatives from any and all responsibility and obligation, and agrees not to hold the Froedtert Health Affiliate liable for any or all injuries, losses, damages or expenses which may occur as a result of any act or omission of the Froedtert Health Affiliate, its members, directors, officers, employees or representatives, or which may arise from the Observer’s observation experience at the Froedtert Health Affiliate.

**Illness** - The Observer hereby forever releases and shall discharge all claims and causes of action whatsoever, present and future, against the Froedtert Health Affiliate, its directors, officers, employees and agents, related to or arising out of any illness, disease or health condition the individual may contract, develop or come into contact with while on the premises of the Froedtert Health Affiliate.

**Medical Treatment** - The Observer agrees the Froedtert Health Affiliate shall provide or refer the Observer for outpatient treatment in the case of an accident or illness while in the Froedtert Health Affiliate facility. In no circumstances shall the Froedtert Health Affiliate bear the cost of the medical treatment.

**Froedtert Health Affiliate Policies** - The Observer agrees to conform to all policies and procedures including those relating to safety, patient care and non-discrimination. These policies and procedures include all standards covered by the Froedtert Health Affiliate’s Code of Conduct, Joint Commission (JC) and Occupational Safety and Health Administration (OSHA) requirements.

**Medical Conditions** – To avoid exposure of risk to any of the Froedtert Health Affiliate’s patients or staff the observer must be free from any communicable disease(s).

## Observer Signature

I certify that the information in this document and any attached documents is true, correct, and complete. I understand and agree that any misrepresentation, misstatement, or omission from this application, if discovered after Observer status has been awarded to me, may lead to termination of my participation in the Observer Experience.

Printed Name of Observer	Date
Signature of Observer	Academic Institution / Year in school (if applicable)
If under 18, signature of parent or legal guardian and relationship	Date

## Mentor Signature

Printed Name of Mentor	Date
Signature of Mentor	Department