OBSERVER ACKNOWLEDGEMENT FORM

This is to attest that I have read and understand the Infirmary Health Observer Orientation document that includes the following training:

- Introduction to the Organization
- Dress Code
- Observer Role and Rules of Conduct
- HIPAA/Confidentiality
- Safety Procedures
- Infection Prevention
- Anti-Harassment Policy

In addition, as an individual participating in an observation at Infirmary Health System, Inc., I understand my duty to maintain confidentiality. I understand I have the responsibility to maintain in confidence all information learned about patients, employees, or the business of operations at Infirmary Health System, Inc. I have read the HIPAA/Confidentiality Observer Orientation and I understand my responsibility towards meeting its requirements.

By signing below, I agree that I have read and understand all policies and procedures related to confidentiality and will seek to maintain and protect the information to which I am exposed during the observation. I also understand that violations of the Confidentiality Policy may result in corrective or disciplinary action with the Institution I am representing.

I have provided the following items for my observation experience:

- Copy of my current unexpired driver's license
- Copy of immunization record
- Proof of current PPD (TB test)
- Proof of current flu vaccine
- Copy of observer consent form

I understand that if I decline or am unable to have a flu shot or TB test, I will be required to wear a mask when I am within six feet of a patient. I also understand that I will not report for observation if experiencing fever, diarrhea, nausea, vomiting, or coughing. I must be 24 hours free of any of these symptoms without the use of medications such as antipyretics, antidiarrheal meds etc. which can mask or hide symptoms.

_____ _____

Observer Signature Date

_____ _____

Observer Phone Number Requested Observation Date(s)

I take responsibility for the signee above during the observation experience. I understand that I am required to inform patients of this observer's participation.

_____

Responsible Preceptor / Physician Name (Please Print)

_____ _____

Responsible Preceptor / Physician Signature Date