WINTER NEUROLOGY OBSERVATION APPLICATION

To be completed by observation applicant.

Full Name:_____ Date of Birth:_____

Email:_____ Phone:_____

Address:_____ City/State:_____

School (if applicable):_____

Career Study/Interest:_____

List three Goals for this Observation: (1)_____

(2)_____

(3)_____

Emergency Contact Name:_____ Phone:_____

Are you currently or have you ever been employed by Confluence Health? (Please check one): NO YES

By your signature below, you agree to the following:

1. I understand that the observation provided is done to assure legitimate access to Confluence Health (CH) hospitals and clinics for educational purposes only.
2. I understand that all information about patients, whether it is medical or personal, is absolutely confidential.
3. I understand that as an observer, regardless of background and training, I may not have any physical patient contact, perform any medical procedures, or have unsupervised access to patients.
4. I agree to hold harmless Confluence Health from any present and future liability and/or damages for injuries arising from or growing out of this observational experience.
5. I agree that should I become ill or injured while on the premise of CH, I can be treated at CH at my own expense.
6. I agree to adhere to the CH appearance and dress code policy.
7. I agree to adhere to parking policies and rules specific to the observation site.
8. I agree to return the identification badge to the provider or employee observed on completion of the observation.
9. I agree to contact the provider or employee I will observe in the event I am unable to attend my scheduled observation date and time.

Applicant Signature:_____ Date:_____

Parent/Guardian Print Name (if under 18):_____ Date:_____

Parent/Guardian Signature (if under 18):_____ Date:_____

Return this completed form to CH Student & Resident Services.