Physician/Professional Observer Application and Orientation Process

Must be 18 or older to observe. Exceptions: Students 16+ years of age may be considered when providing an appropriate written recommendation by a school official. Also visiting physicians, allied health and nursing will be considered on a case-by-case basis. This process is not offered for those completing the credentialing process.

Complete/Produce the required documents below:

1. **Observer Data Sheet**
2. **Signed Observer Guidelines**
3. **Signed Code of Conduct**
4. **Supervising Physician/Professional Agreement - Must be signed by physician for APRN with Inclusive Dates of the observation timeline.**
5. **Proof of the following Vaccinations:**
   - **COVID-19**
   - **Tuberculosis test (TB Test) taken within the past year or completed symptom review form and recent chest X-ray report if you are a positive reactor. (Form attached)**
   - **Influenza when rotating between October and March**
   - **Hep B and/or titer**
   - **MMr x2 or titers**
   - **Tdap – Every 10 years**
   - **Varivax x2 or titers**
6. **Read and sign the Confidentiality Statement.**
7. **Current Professional Picture (JPG format) for your Covenant Badge**
8. **Health Screening Form**
9. **Consent and Release of Medical Information**

If you are observing surgeries, you will also need to attend an OR Orientation. Allow two weeks for processing prior to the start of your observation. You may not begin shadowing without a Covenant Security Badge or having completed Online Orientation.

NOTE: Please submit your completed application and all supplemental documents by email to bradleyrd@covhs.org or by fax to (806)723-7146.

Mission, Vision and Promise:

Covenant Health Mission:
As expressions of God's healing love, witnessed through the ministry of Jesus Christ, we are steadfast in serving all, especially the poor and vulnerable.

Covenant Health Vision:
Health for a better world

Our Promise:
"Know me, care for me, ease my way."

OBSERVER DATA SHEET

I am requesting Observation privileges as a (select one):

☐ Pre-med student ☐ Non-TTUHSC Resident ☐ Physician Observer ☐ Medical Student – Year _____

☐ Health Careers Student (NP, PA, OT, PT, SLP, etc.) ☐ Other _____

Are you presently going through the Credentialing Process with Covenant Health Medical Staff Services? Yes ☐ No ☐

OBSERVER INFORMATION:

Full Name: _____

First Middle Last Credentials

Date of Birth: _____ **SS#:** **Male** ☐ **Female** ☐

Month Day Year

Address: _____

Cell Phone: _____ **Email Address:** _____

EDUCATION/ADVISOR INFORMATION:

Name of School - _____

School Address - _____

School Advisor - _____ **Advisor's Email -** _____

Advisor's Phone - _____ **Advisor's Fax -** _____

COVENANT SUPERVISOR FOR SHADOWING EXPERIENCE/LOCATION:

Name/Specialty - _____

If a mid-level, what is the name of their Supervising Physician? _____

Physical Location of your Observation? ☐ CMC ☐CCH ☐CSH ☐JACC ☐Plaza ☐CMG Clinic ☐Hobbs

☐Grace Clinic ☐Grace Hospital ☐ Covenant Plainview ☐Covenant Levelland ☐ Other - _____

Are you currently employed by Covenant Health? ☐ Yes ☐ No Which campus? _____

Will any rotation you have involve an invasive procedure? OR, Cath Lab, or L&D? ☐ Yes ☐ No

If yes, what is your Scrub Size? (Tops/bottoms must be the same size. Size range is XS –4X.) _____

GUIDELINES FOR MEDICAL STAFF OBSERVERS AT COVENANT HEALTH

1. **Permission to observe a Medical Staff member of Covenant Health entities is given as a public service to further interest in healthcare careers.**

2. **Observers may not provide any services related to provision of medical care to patients including, but not limited to diagnosing diseases, administering medications, performing surgical procedures, suturing, providing medical advice or any other tasks generally reserved for the trained health professional. The only exception to this policy is with the second-year medical students. MS2 students during their Community Preceptorships are allowed to gather a patient's history, administer a physical exam, document a patient visit and generate a basic differential diagnosis and plan for the patient condition.**

3. **Photography of any kind is strictly forbidden in any patient care area or other location that could violate patient confidentiality.**

4. **Observers must always remain with the Supervising Physician while in patient care areas of the hospitals.**

5. **Patients have the right to refuse to have Observers present for any examination, procedure, test, or surgery.**

6. **Observers must always wear a Covenant badge above the waist in a visible manner while on Covenant Health premises.**

7. **Observers must dress in attire consistent with Covenant Health policies and procedures.**

8. **Observers must maintain strict confidentiality and privacy in accordance with hospital policies and procedures and the Health Insurance Portability and Accountability Act (HIPAA).**

I have read and agree to abide by the Guidelines for Observers at Covenant Health. To the best of my knowledge, all information I have supplied is accurate and complete. I hereby release and hold harmless Covenant Health and all their related and/or affiliated entities along with their respective directors, officers, representatives, agents, licensees, and/or employees, of all liability, damages, causes of action, suits, claims, or judgments relating to my participation at Covenant. This release and hold harmless shall be binding upon me and my heirs, executors, administrators, and assigns.

Observer Signature _____ Date _____

Code of Conduct

Covenant Health desires that all patient care activity take place in an atmosphere of collegiality, cooperation, and professionalism. Members of the Medical Staff/Observers are expected to conduct themselves in a manner consistent with and supportive of Covenant Health System's mission, vision, and core values.

Mission and Values

Members of the Medical Staff acknowledge that Covenant Health is a faith-based ministry based on Catholic and Methodist traditions and principles whose mission is "As expressions of God's healing love, witnessed through the ministry of Jesus Christ, we are steadfast in serving all, especially the poor and vulnerable". Our five core values – Compassion, Dignity, Justice, Excellence, and Integrity – serve as guiding principles.

Respectful Treatment

All members of the Medical Staff/Observers of Covenant Health System (Hospital) shall treat others with respect, courtesy, and dignity and conduct themselves in a professional and cooperative manner.

Safe Environment of Care

Members of the Medical Staff/Observers acknowledge and agree that the protection and safety of patients, employees, physicians and others in the Hospital and the orderly operation of the Hospital are paramount.

Patient Care

Members of the Medical Staff/Observers agree to provide care to patients consistent with generally recognized standards of care. Medical Staff members further agree to actively help educate patients and their families regarding the medical condition for which the patients are receiving care and treatment. Additionally, members of the Medical Staff/Observers agree to coordinate care, treatment, and services with other practitioners and Hospital staff as appropriate and seek consultation whenever warranted by patient's condition. Medical Staff members/Observers also agree to provide continuity of care for patients and delegate responsibility of diagnosis and/or treatment of hospitalized patient to a practitioner who is qualified to provide necessary care.

Language and Behavior

Members of the Medical Staff/Observers agree to refrain from engaging in any behavior that may impair the ability of the healthcare team to provide quality care and/or otherwise create a hostile or intimidating work environment. Prohibited conduct includes, but is not limited to, making offensive or derogatory comments, racial or ethnic slurs, sexual comments/innuendos, threats of violence, using foul language, acting in a rude, intimidating or otherwise unprofessional manner, engaging in retaliatory conduct, criticizing individuals in inappropriate forums.

Harassment/Discrimination

Members of the Medical Staff/Observers also agree to refrain from engaging in any form of unlawful discrimination or harassment based upon any legally protected characteristic, including race, color, religion, national origin, sex, sexual orientation, pregnancy, age, disability, or military status. Harassment is defined as unwelcome verbal, visual, or physical conduct that creates an intimidating, offensive, or hostile work environment that interferes with work performance. Sexual harassment, specifically, includes making unwelcome sexual advances, requests for sexual favors, or other verbal or physical conduct of a sexual nature that is unwelcome and offensive to individuals who are subjected to it or who witness it.

Because of the unique legal implications surrounding sexual harassment, a single confirmed incident requires a meeting to be held with the Medical Staff member/Observers to discuss the incident.

Corrective Action for Inappropriate Conduct

Collegial and educational efforts may be used by Medical Staff leaders to address inappropriate conduct. Collegial steps, including counseling, warnings, and meeting with a practitioner, may be taken to address complaints about inappropriate conduct. However, a single incident of inappropriate conduct or a pattern of inappropriate conduct may warrant immediate corrective action in accordance with the Medical Staff Bylaws, Rules and Regulations.

Confidentiality
Members of the Medical Staff/Observers agree to always maintain confidentiality of patient care information, in a manner consistent with all relevant laws. Members of the Medical Staff/Observers shall also abide by the Medical Staff Rules and Regulations regarding confidentiality of peer review files and process.

Compliance
Members of the Medical Staff/Observers agree to abide by Hospital Bylaws, Medical Staff Bylaws, Rules and Regulations and policies, applicable laws and regulation of governmental agencies, Corporate Compliance policies, and applicable standards of accrediting organizations including the Joint Commission on Accreditation of Healthcare Organizations. Failure to comply with the provisions of this Code of Conduct policy may result in corrective action in accordance with the Medical Staff Bylaws, Rules and Regulations.

Reporting Concerns about Safety or Quality of Care

Members of the Organized Medical Staff/Observers are encouraged to report their concerns about patient safety or quality of care to any of the following Covenant Health System (CHS) leadership: Chief Executive Officer, Chief Operating Officer, Chief Medical Officer, Chief of Staff, or the Medical Director of Quality. Concerns may also be reported to any member of the Joint Commission/Regulatory department at 725-3838. By reporting issues directly to Covenant leadership, it will help us conduct a timely and appropriate response.

In keeping with our commitment to meet the Joint Commission standards, CHS takes this opportunity to inform you that if you have concerns about patient safety and quality of care here at CHS, you may also choose to report concerns to the Joint Commission at 1-800-994-6610, or online at www.jointcommission.org

Any member of the Medical Staff/Observers can report directly to the Joint Commission without fear of retaliatory or disciplinary action being taken by Covenant Health System.

Code of Conduct Attestation

By my signature below, I certify that I have received and agree to Covenant Health's CODE OF CONDUCT. I agree to comply fully with the standards, policies, procedures, and other provisions of the Code of Conduct. I understand that compliance with the provisions contained in the Code of Conduct are a condition of obtaining and retaining medical staff/Observer credentials and privileges at Covenant Health. I also understand that the Covenant Health may from time to time amend, modify, and update the Code of Conduct pursuant to the Bylaws and Rules and Regulations of the Covenant Health and the Medical Staff/Observers.

Printed Observer Name: _____

Observer Signature: _____

Date: _____

SUPERVISING PROFESSIONAL/PHYSICIAN AGREEMENT FOR OBSERVERS

I agree that the Observer's presence with me shall be for the purpose of observation only, and that he/she may not perform any procedures, either in assistance with me or individually. OBSERVERS MUST WEAR A SHIELD AND MASK UNLESS THEY PROVIDE PROOF OF RECEIPT OF THE COVID-19 VACCINE PRIOR TO THEIR ROTATION, AND MUST NEVER BE IN COVID UNITS. Observer agrees that he/she shall respect the wishes of any patient who objects to his/her presence and that he/she shall abide by the policies and procedures of all Covenant Health entities and comply with the provisions of the Health Insurance Portability and Accountability Act. I also understand providers I must have the Instruction and/or Supervision of NP/PA/Medical Students, Residents and Fellows Privileges within Covenant Health to participate in this student's clinical rotation.

I agree that I shall be responsible for all the Observer's acts and omissions while he/she is with me at Covenant. I hereby release and hold harmless Covenant Health and all their related and/or affiliated entities along with their respective directors, officers, representatives, agents, licensees, and/or employees, of all liability, damages, causes of action, suits, claims, or judgments relating to Observer's participation with me at Covenant. This release and hold harmless shall be binding upon the Observers and my heirs, executors, administrators, and assigns.

1.) _____ _____

Signature of Supervising Professional/Physician **Inclusive Dates of Rotation**

_____ **Specialty: ☐ Medicine ☐ Surgery**

Printed Name

☐ Other: _____

Observer will rotate with me at: ☐ CMC ☐CCH ☐ CMG Clinic ☐ Hobbs ☐ Cath Lab

☐ Plaza ☐CSH ☐Grace Clinic ☐Grace Hospital ☐Covenant Plainview

☐Covenant Levelland ☐ Other - _____

2.) _____ _____

Signature of Supervising Professional/Physician **Inclusive Dates of Rotation**

_____ **Specialty: ☐ Medicine ☐ Surgery**

Printed Name

☐ Other: _____

Observer will rotate with me at: ☐ CMC ☐CCH ☐ CMG Clinic ☐ Hobbs ☐ Cath Lab

☐ Plaza ☐CSH ☐Grace Clinic ☐Grace Hospital ☐Covenant Plainview

☐Covenant Levelland ☐ Other - _____

_____ _____

Student - Print Name **Date**

_____

Student Signature

CONFIDENTIALITY STATEMENT

(For Students/Observers/Volunteers)

As a student, observer or volunteer performing duties at Covenant Health (CH), you will have access to the protected health information (PHI) of patients. Federal and State laws, including HIPAA and other policies and procedures created internally, protect the privacy and security of this PHI, including the fact that an individual was a patient at CH. It is illegal for you to use or disclose PHI outside the scope of your duties at CH. This includes oral, written, or electronic uses and disclosures. Below are some guidelines that you must be familiar with regarding the use of a patient's PHI.

1. **You may use PHI as necessary to carry out your duties as a student/volunteer.**
2. **You may share PHI with other health care providers within CH for the direct treatment of the patient.**
3. **You may NOT photocopy or otherwise permit PHI to be duplicated in anyway.**
4. **You may NOT photograph patients.**
5. **You must access only the minimum amount of PHI necessary to care for a patient or to carry out an assignment.**
6. **You may NOT record PHI (such as patient names, diagnoses, dates of birth, addresses, phone numbers, Social Security numbers, etc.) on any assignments you may need to turn in to your instructor, reports you may need to turn in to your program, or forms you may need to take with you.**
7. **You may only access the PHI of patients for whom you are caring/volunteering when there is a need for the PHI.**
8. **You must be aware of your surroundings when discussing PHI. As an example, it is inappropriate to discuss PHI in elevators, bathrooms, the cafeteria, and any other place for which your discussion may be overheard.**
9. **When disposing of any documents with PHI, do NOT place them in the trash can. Instead, the documents should be placed in the proper containers marked for shredding or another disposal container as set forth by policy and procedures for your specific department.**
10. **If you have questions about the use or disclosure of PHI, contact the Compliance and Privacy Officer (806.725.0085).**

Please read, sign, and date this acknowledgement. Return it Medical Staff Services where it will be filed with your application.

Acknowledgment

I have read and I understand the information in this document. I realize that there are penalties for which I may be subject, including criminal, for the unauthorized use and disclosure of PHI. I agree to abide by the guidelines described above when performing my duties at Covenant Health.

I understand and agree that in the performance of my duties within any Covenant Health entity, I may become aware of information that could be considered confidential. It is my responsibility to protect the privacy of patients, employees, and the hospital. I understand that my failure to comply may result in disciplinary action from my physician supervisor.

Name (Print):_____ **Date:**_____

Signature: _____

TUBERCULOSIS SCREENING QUESTIONNAIRE

Providence St. Joseph Health

Name:_____ **Date of Birth:**_____ **Caregiver ID #:**_____
Last First Middle

Dept:_____ **Home/Cell Phone #:** _____

☐**Caregiver/Applicant** ☐**Volunteer** ☐**Other:** _____

DO YOU CURRENTLY HAVE SYMPTOMS OF:		**If yes, please explain**
1. Persistent and/or productive cough for more than three weeks?	☐Yes ☐ No	
2. Cough for more than one week following confirmed TB exposure?	☐Yes ☐ No	☐N/A
3. Prolonged low grade fever associated with cough for more than 1 week?	☐Yes ☐ No	
4. Blood present in sputum?	☐Yes ☐ No	
5. Unexplained night sweats (unrelated to menopause)?	☐Yes ☐ No	
6. Unusual fatigue for more than two weeks?	☐Yes ☐ No	
7. Loss of appetite for more than two weeks?	☐Yes ☐ No	
8. Unexplained weight loss of five pounds or more?	☐Yes ☐ No	
CURRENT HEALTH STATUS:		**If yes, please explain**
9. Do you have an acute viral infection or febrile illness?	☐Yes ☐ No	
10. Have you had a live-virus vaccine in the past four weeks?	☐Yes ☐ No	
11. Are you on or planning to begin immunosuppressive therapy or treatment for: diabetes, human immunodeficiency virus (HIV) infection, organ transplant recipient, undergoing radiation therapy, chemotherapy, treatment with a TNF-alpha antagonist (e.g., Infliximab, etanercept, or other), chronic steroids (equivalent of prednisone >15 mg/day for >1 month) or other immunosuppression medication? (*)	☐Yes ☐ No	
HISTORY:		**If yes, please explain**
12. Have you lived or visited (more than one month) in a country with a high TB rate? (Any country other than the United States, Canada, Australia, New Zealand and those in northern Europe or Western Europe). (*)	☐Yes ☐ No	
13. Have you had unprotected close contact with someone who has had infectious TB disease in the past 12 months or since your last TB test? (*)	☐Yes ☐ No	Relationship:
14. Have you received the BCG vaccination?	☐Yes ☐ No	
15. Have you ever had a positive TB skin or blood test?	☐Yes ☐ No	Date:
16. Have you had a chest x-ray related to TB?	☐Yes ☐ No	Date:
17. Have you ever been treated with TB medications?	☐Yes ☐ No	

Please note: HIV infection and other medical conditions may cause a TB test to be negative even when TB infection is present. Persons with HIV infection and certain other medical conditions that may suppress the immune system are at significant risk of progressing to TB disease if they have TB infection. If you have HIV infection or other medical conditions that may suppress the immune system, discuss your risk of TB with your primary care provider.

To my knowledge, the above information is correct. I consent for an IGRA (TB) blood test, and/or chest x-ray, if applicable.

Applicant/Caregiver Signature:_____ **Date:** _____

For Clinic Use Only

(*) Risks: if any one question is marked yes, refer back to TB algorithm.

***(!)* Any questions 1-8 marked positive refer to TBQ Scoring Grid Standard Work.**

Caregiver Health Nurse Review: Based on current TB algorithm, I have reviewed the above and recommend:
☐IGRA ☐TST ☐Symptom review only

Caregiver Health Nurse Name (print):_____ Signature:_____ Date: _____

IGRA: Draw Date:_____ Review Date:_____ IGRA Results: ☐Negative ☐ Positive

IGRA: Draw Date:_____ Review Date:_____ IGRA Results: ☐Negative ☐ Positive

Follow-up Action: ☐ No further follow up needed CHN Name:_____

CXR ordered; Date:_____ Results: ☐Negative ☐ Positive CHN Name:_____

For known history of positive TB test: TST on file? ☐Yes ☐No Date:_____ If yes, IGRA drawn? ☐Yes ☐ No

IGRA on file? ☐Yes ☐ No Date:_____ CXR on file? ☐Yes ☐ No Date:_____ Results: ☐ Neg ☐ Pos

Volunteer Screening Form

Name:_____ Date of Birth:_____ Gender: _____
Last First Middle

Address:_____ City:_____ State: _____ Zip: _____

Email address: _____

Phone number:_____ Alternate phone number: _____

Best time to call:_____ Supervisor: _____

Region:_____ Facility/Department:_____ Position: _____

Start date: _____

Please complete the following to the best of your knowledge. This will become a part of your Caregiver Health Services (CHS) file. All medical information is confidential.

I understand the following:

❑ **Yes**	I understand, if applicable, I am willing and able to wear required safety equipment such as gloves or a surgical mask, on the job. If no, please explain:_____
❑ **Yes**	I understand, if I have ever had any reaction to any latex product (e.g., rash, swelling, anaphylaxis, burning after contact) that I would inform my Caregiver Health Services professional.
❑ **Yes**	I understand that titers will be drawn, and I will be notified of my immune status and if I am not immune, I may be vaccinated Caregiver Health Services.
❑ **Yes** ❑**NA**	I am under age 18 and understand that I must being in my immunization records from by my primary care provider. I must have my parent's signature before any procedures can be done.

Applicant signature:_____ Date: _____

Caregiver Health signature:_____ Date: _____

Consent and Release of Medical Information

Name:_____ Date of Birth: _____
Last First Middle

I authorize the Providence Health & Services designee(s) to administer immunization(s), TB skin testing/TB blood testing, and other preventative, or diagnostic treatments for illness or injury sustained during the course of my work. This Authorization also includes treatment for minor non-industrial injuries/illnesses.

This authorization does not prevent me refusing treatment at a later date. It remains in effect during my volunteer assignment at any Providence Health & Services and Kadlec facility. Commonly administered injections include TB skin test, tetanus & diphtheria, tetanus, diphtheria & pertussis, MMR (measles, mumps & rubella), varicella and influenza. Additional testing may be ordered, such as chest x-rays or lab testing. This is to rule out Tuberculosis and test for immunity status.

All individually identifiable information in the Caregiver Health Service (CHS) record is maintained in said department in accordance with state and federal statutes and regulations. Information will be disclosed if that information is deemed relative regarding suitability for volunteering, ability to perform essential volunteer functions.

In the event of a work-related injury/illness sustained while volunteering at Providence Health & Services and Kadlec, information may be provided to those involved in the administration of my Workers Compensation Claim.

- **Work related incidents/injuries need be reported to your Volunteer Coordinator.**
- **Communicable disease related illnesses/exposures should be reported to Caregiver Health.**

Findings of initial health screen and any other examinations will be reviewed by the CHS nurse or designee. I have read this document and I have been given an opportunity to ask questions.

Volunteer Signature:_____ Date: _____

CHS Representative:_____ Date:_____

Parental Consent

_____#_____
(PRINT Parent/Legal Guardian Name) **Phone number**

I give Providence Caregiver Health Services permission to draw blood for Tuberculosis Testing and titers.

X_____ Date: _____
Signed by parent or legal guardian for volunteer/student under 18 years of age