Observational Activity Application Checklist

Persons involved in observational activities in St. Catherine of Siena Medical Center must:

Submit a completed Application and Agreement for Observational Activity Form.

Submit a completed SCSMC Immunization Health History Form.

Attach a copy of current government issued photo ID.

If approved, obtain security badge from SCSMC prior to Observational Activity start date
(You will receive a letter of approval from Medical Affairs –
Please call Human Resources 862-3025 to set up an appointment)

Once completed, please return this form to:
St. Catherine of Siena Medical Center
50 Route 25A
Smithtown, NY 11787
Attention: Department of Medical Affairs

If you have any questions, please contact:

Medical Staff Affairs
(631) 862-3040

ST. CATHERINE OF SIENA
Medical Center
Healthcare Excellence Close to Home©

Sponsor Statement for Observational Activity

To be completed by the sponsoring person at SCSMC

Applicant's Name: ____________________________________

- I KNOW THIS APPLICANT AND BASED ON MY KNOWLEDGE OF THIS APPLICANT, CURRENT COMPETENCE, AND HEALTH STATUS AS IT AFFECTS PERFORMANCE
- I ATTEST THAT THIS PERSON IS PHYSICALLY AND MENTALLY COMPETENT TO OBSERVE IN ST. CATHERINE OF SIENA MEDICAL CENTER AND/OR ITS AFFILIATES AND IS OBSERVING FOR THE PURPOSE OF MEDICAL EDUCATION, RESEARCH AND/OR TRAINING.
- I ATTEST THAT THE PURPOSE OF THIS IS NOT SOLELY FOR THE BENEFIT OF A COMMERCIAL VENDOR. I ALSO ATTEST THAT I WILL RECEIVE THE PERMISSION OF THE PATIENT(S) FOR THIS PERSON TO OBSERVE. A SEPARATE CONSENT FORM HAS BEEN COMPLETED FOR OBSERVATION IN THE O/R AND PROCEDURAL AREAS. THIS CONSENT WILL BECOME A PERMANENT PART OF THE MEDICAL RECORD.
- THE PERSON OBSERVING WILL BE IN MY PRESENCE AT ALL TIMES: YES NO
- IF NO, PLEASE INDICATE BELOW WHO WILL SUPERVISE THE PERSON OBSERVING:

  ____

Please Note: The supervising physician should introduce the visitor to the patients.

Sponsoring Physician Signature: ____________________________ **Date:** ____________

Please Print Name: ____________________________________

Administrative Signature: ____________________________ **Date:** ____________

Please Print Name: ____________________________________

5/09

ST. CATHERINE OF SIENA
Medical Center
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St. Catherine of Siena Medical Center
Application and Agreement for Observational Activities

Please fill this form out completely and legibly. Incomplete and/or illegible forms will not be accepted.

Applicant Name:		
Day Phone:	**Evening Phone:**	**Email Address:**
Street Address:		
City:	**State:**	**Zip Code:**
School (if Applicable):		
Career/Study Interest:		
I am 18 years of age or older: YES NO **Please Note: If you are not at least 18 years of age, you MUST have a parent or guardian sign this form.**		
Company Name:	**Current Job Title:**	
Work Address:	**Company Phone Number:**	
Have you ever been convicted of a misdemeanor and or felony? NO YES **If YES, please attach an explanation with the date of occurrence.**		
Have you ever had your license revoked or denied? NO YES **If YES, please attach an explanation.**		
I have spoken with a person affiliated with SCSMC and they have agreed to participate in my observational experience. If checked, please fill in the shaded boxes below telling us about your contact person.		
Contact Name:	**Title:**	
Department:	**Phone:**	
Please indicate the date(s) that you would like to participate in Observational Activity:		
If you are a medical professional, what is your profession?		
What degree(s) do you currently hold?		
Reason for observing at SCSMC: (Please check one of the following) I am a medical professional seeking additional experience. I am a medical professional seeking to observe at the invitation of ____________________. Other: Please explain: ____________________ ____________________		

Applicant Attestation:

Applicant must read and sign in the box below indicating your agreement to all the conditions stated.

- I understand that the observational activity provided is done as a public service in the interest of education.
- I understand that all information about patients, whether it is medical or personal, is absolutely confidential.
- I have read and signed the confidential acknowledgement form listed on the back of this page.
- I understand that as an observer, regardless of my background and training, I may not perform any medical procedures.
- I will not have direct contact with patients, nor have unsupervised access to patients.

I agree to the following statements:

- ✓ My required immunizations are current and I have completed and attached my immunization records.
- ✓ I have not been exposed to measles, rubella or chickenpox in the last 30 days.
- ✓ If this observational assignment lasts more than 3 weeks, I will report to the SCSMC Employee Health Office for a tuberculosis screening.
- ✓ I agree to hold harmless St. Catherine of Siena Medical Center from any present and future liability and/or damages for injuries arising from or growing out of this observational experience

Signature of Applicant:	***Date:***
Signature of Parent or Guardian (if under 18 years of age):	***Date:***

CONFIDENTIALITY ACKNOWLEDGEMENT FORM FOR OBSERVATIONAL ACTIVITIES

To be completed by the person applying for Observational Activities at SCSMC

SCSMC has a legal and ethical responsibility to safeguard the privacy of all patients and protect the confidentiality of their protected health information. Strong federal and state laws govern privacy of our patients and their health information.

When you participate in an observational experience at SCSMC, you are involved in a unique experience. You will be accompanying a health care professional for a specified period of time in a health care facility. During this time you will or may be seeing patients with a variety of medical issues and/or you may see and hear confidential information relating to these patients. This relates to information past, present and future.

As a condition of participating in this observational experience, I understand and agree that:

- I must maintain and safeguard the confidentiality of any and all SCSMC protected health information.
- I will not access, use or disclose protected health information unless specifically approved as part of my observational experience.
- I will maintain all protected health information in the strictest confidence and will not disclose or allow access to protected health information to others.
- Any access to protected health information may be monitored to assure appropriate compliance with system integrity and SCSMC policies and procedures.
- If I fail to comply with the above confidentiality guidelines, or if I breach patient confidentiality, this agreement will be terminated and my ability to participate in future activities at SCSMC may be denied.

Signature of Applicant:	***Date:***
Signature of Parent or Guardian (if under 18 years of age):	***Date:***

Based upon current standards of OSHA/AHA/Joint Commission and Hospital policy, applicants to observe within the Medical Center are required to forward their immunization/test records to the Department of Medical Affairs. For your convenience, a standardized reporting form is enclosed. Specifically, documentation of the following is required:

- ☐ **MEASLES:** (for those whose date of birth is 1/1/57 or later), statement of history of illness is not acceptable. You must present:
  1. A statement of date of positive antibody titer.

  OR
  2. Date of immunization (done after 1/1/69).

- ☐ **RUBELLA:** (for those whose date of birth is 1/1/57 or later), statement of history of illness is not acceptable. You must present:
  1. A statement of date of positive antibody titer.

  OR
  2. Date of immunization (done after 1/1/69).

- ☐ **MUMPS:** Statement of history of illness is not acceptable. You must present:
  1. A statement of date of positive antibody titer.

  OR
  2. Date of immunizations (must provide documentation of 2 vaccinations received after your 1st birthday done at least one month apart.

- ☐ **HEPATITIS B:**
  1. A statement of date of positive antibody titer.

  OR
  2. Date of completion of immunization series.

  OR
  3. Sign attached waiver.

- ☐ **VARICELLA-ZOSTER VIRUS:** A statement of history of illness (chicken pox, shingles or varicella-zoster). If negative history, the results of antibody titer.

- ☐ **TB SKIN TEST:** A statement indicating the result of Montoux Skin Test done within the last year.
  1. Negative result will require annual TB skin testing.
  2. If positive, please provide reason (exposure or BCG vaccination) date of evaluation, summary of treatment and chest x-ray report since first becoming positive.

To become compliant if your records are unavailable, please arrange testing and reporting with your personal healthcare provider.

ST. CATHERINE OF SIENA
Medical Center

50 Route 25A ♦ Smithtown, NY 11787
Phone: (631) 862-3000 Fax: (631) 862-3105

IMMUNIZATION TESTING RECORD

NAME (PLEASE PRINT):	
Department:	
SS#:	
DATE:	

DOCUMENTATION OF IMMUNIZATIONS/ TITERS

	DATE	RESULT
RUBEOLA VACCINE		
RUBEOLA TITER (if no vaccine)		
RUBELLA VACCINE		
RUBELLA TITER (if no vaccine)		
MMR VACCINE		
Have you ever had chickenpox?		YES NO
VARICELLA TITER (If done):		
VARICELLA VACCINATION (If done, but not required):		
PPD, MANTOUX (within last year, if PPD-Negative)		POSITIVE NEGATIVE
If PPD Positive, did you have a chest x-ray within the last year?		YES NO
If PPD Positive, did you receive prophylactic anti-tuberculosis therapy?		YES NO
Have you received the Hepatitis B Vaccine series?		YES NO
What was the result of your Hepatitis B surface antibody test following the vaccine series?		POSITIVE NEGATIVE

FAIR CREDIT REPORTING ACT CONSUMER DISCLOSURE AND AUTHORIZATION

Facts You Need to Know:

In connection with my application for employment with St. Catherine of Siena Medical Center, they may obtain a consumer report on you, as defined in the Federal Fair Credit Reporting Act, 15 U.S.C. 1681 *et seq*. It may be an "investigative consumer report" that includes information as to your character, general reputation, personal characteristics, and mode of living, whichever are applicable. If St. Catherine of Siena Medical Center obtains an investigative consumer report, you have the right to request disclosure of the nature and scope of the report, which involves personal interviews with sources such as your neighbors, friends, or associates.

St. Catherine of Siena Medical Center may not obtain any consumer report on you for employment purposes/medical staff privileges without your written consent. Also, St. Catherine of Siena Medical Center may not obtain medical information about you without your express consent to the release of medical information. Consent to the release of medical information, is *not* covered by the authorization contained in this document.

State-specific information:

- California – If you are a California resident or applying for employment at a location in the State of California, in addition to this disclosure/authorization, please review and complete the "Disclosure and Acknowledgement Concerning Consumer Credit Report or Investigative Consumer Report Obtained for Employment Purposes Pursuant to California Law." ☐

- Minnesota – If you are a Minnesota resident or applying for employment at a location within the State of Minnesota, you have a right to obtain a copy of the consumer report by checking this box. ☐

- Oklahoma – If you are an Oklahoma resident or applying for employment at a location within the State of Oklahoma, you have a right to obtain a copy of the consumer report by checking this box. ☐

Consent and General Authorization to Obtain Consumer Report

I hereby authorize St. Catherine of Siena Medical Center, now or at any time while I am employed by St. Catherine of Siena Medical Center, to obtain a consumer report, or an investigative consumer report, on me. This authorization does not authorize the release of medical information.

Please list all residences lived at in the past 7 years:

Address: **Years at address:**

______________________ ______________________ ________
First Name (Print) Street Address

______________________ ______________________
Last Name (Print) City State Zip

______________________ ______________________ ________
Middle Name (Print) Street Address

____
City State Zip

Social Security #: ________________

Date of Birth: ________________ ______________________ ________
Street Address

____
City State Zip

Other Names Used:

Name	**From/To**

Previous states/counties of residence:

____
____
____

** This information will be used for purposes of identification only. Federal law prohibits discrimination in employment on the basis of race, color, sex, national origin, religion, age, equal pay or disability. Additionally, New York State law prohibits discrimination in employment on the basis of creed, sexual orientation, military status or marital status.*

______________________ ______________________
Applicant's Signature Today's Date

____
Applicant's Name Printed