Door County Medical Center
IN PARTNERSHIP WITH HOSPITAL SISTERS HEALTH SYSTEM

# ***Observation Request Form***

Participant Name: _____

Date: _____ Department: _____

**Students only**: Name of School: _____

## Tasks to Complete:

1. Review Orientation Handbook
   - This includes:
   - Performance Expectations
   - Mission and Values/ Standards of Behavior
   - Safety Procedures
   - Infection Prevention measures
   - Security/ Emergency Response
   - Patient Rights and Ethics
   - Harassment
   - Privacy/HIPAA/Confidentiality
   - Workplace Violence
2. Answer all questions included in this Orientation Request form
3. Return all completed forms and proof of immunization to the Education Coordinator via email: renee.glesner@dcmedical.org , mailing in is also acceptable.

Signature indicates “Orientation handbook” has been reviewed and Observer reports his/her understanding of material.

Observer’s Signature: _____ _____

Date

Door County Medical Center
IN PARTNERSHIP WITH HOSPITAL SISTERS HEALTH SYSTEM

## Individuals Observing a DCMC Employee

DCMC has agreed to allow selected person to observe professionals. In consideration of DCMC allowing individuals this opportunity, the individual hereby agrees to the following:

**Privacy/Confidentiality**: The individual agrees any patient health information or knowledge acquired or received during the course of the observation at DCMC, 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 permitted by DCMC, be disclosed or used during or after termination of the individual's placement at DCMC without DCMC's prior written consent.

**Release/Indemnification**: The individual agrees t and hereby doe release, indemnify and hold harmless DCMC, its members, directors, officers, employees and representatives from any and all responsibility and obligation, and agrees not to hold DCMC liable for any or all injuries, losses, damages or expenses which may occur as a result of any act of omission of DCMC, its members, directors, officers, employees or representatives, or which may arise from the individual's participation in the Observation Program at DCMC.

**Illness**: The Individual hereby forever releases and shall discharge all claims and causes of action whatsoever, present and future, against DCMC, 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 DCMC.

**Medical Treatment**: DCMC shall provide or refer outpatient treatment to individuals while in the facility for observation program placement in case of an accident or illness. However, in no circumstances shall DCMC be the cost of the emergency outpatient treatment.

**DCMC Policy**: The individual 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 DCMC's Code of Conduct, Joint Commission on the Accreditation of Healthcare Organization (JCAHO) and Occupational Safety and Health Administration (OSHA) requirements.

**Communicable Disease**: The individual agrees to disclose if he/she has had contact with others who have Varicella, Severe Acute Respiratory syndrome, or other communicable diseases that would threaten the safety of patients or staff. I have completed all of the required elements to participate in this experience. I meet the health requirements as outlined in Section I of this agreement, and I have read the "Observation Experience Policy" – specifically the limitations of the observers and the confidentiality requirements and all agree to abide by the policy, and all terms of this agreement.

_____ _____

Observer Signature/Date Guardian Signature/Date

*(If Observer is under 18 years of age)*

Approval:

_____

Education Coordinator /Date

Renee Glesner RN, MSN

Door County Medical Center
IN PARTNERSHIP WITH HOSPITAL SISTERS HEALTH SYSTEM

## OBSERVATION EXPERIENCE AUTHORIZATION FORM

I, * _____,
*(Please Print)* First and Last Name *(Please Print)*

will be participating in an Observation Experience with Door County Medical Center for purposes of personal learning. I or my school requested Door County Medical Center to allow me to observe and I am doing so voluntarily and without any expectation of pay or benefit from Door County Medical Center.
I have been informed that I must at all times accompany the Door County Medical Center associate I am observing on the scheduled and agreed upon observation experience date.

- I have been informed that I am bound by strict policies and procedures involving patient confidentiality. Information regarding patients must not be discussed except for discussion that occurs as part of this observation experience.
- My activities will be limited to **observation only**; I will have no physical patient contact and no participation in direct patient care. I am not allowed to read medical records. I will maintain at all times an observation distance of three (3) feet or greater.
- Door County Medical Center has the right to request that I leave the area of my observation at any time.
- I acknowledge that there are dangers and risks of personal injury or illness inherent in observing the care and treatment of patients.
- Neither Door County Medical Center, nor any of its associates shall be held responsible for any personal injuries which may occur to me on the premises while I participate in the Observation Experience. To the fullest extent allowed by law, I release and forever discharge Door County Medical Center, its agents, employees, representatives, and parent company, from all liability, losses and damages whatsoever incurred by me for any injury or damage of any kind and in any amount, relating in any way to, or arising out of, my participation in the Observation Experience. I read this document, understand its contents, and agree to its terms and conditions freely and voluntarily.
- Should I need medical attention during or as a result of this observation experience, I assume full responsibility for any treatments deemed necessary. I assume responsibility for all medical costs which result and release Door County Medical Center of all liability.
- I give my permission for Door County Medical Center to release my telephone number or contact information to appropriate departments.
- Patients of the Door County Medical Center associate I am observing will be informed of my observation experience and have the right to allow or not allow me to observe their medical care.
- I have read the Career Exploration Orientation and agree to adhere to those guidelines.
- I agree that on my scheduled Observation Experience date I am free from communicable diseases, which include no fever, cough, malaise, diarrhea, nausea/vomiting. If I am not, I will contact Door County Medical Center to cancel my Observation Experience and attempt to reschedule it.
- I am current in all immunizations as required.

**I have read and agree to the conditions of participation as outlined above. The signatures below acknowledge that all persons signing below have read, understand, and accept the terms of participation as outlined above.**

_____ _____

*Signature of student Date Signature of Parent/Guardian (if minor) Date

Renee Glesner RN, MSN

Door County Medical Center
IN PARTNERSHIP WITH HOSPITAL SISTERS HEALTH SYSTEM

## Health Requirements: You must provide documentation for all of the following

1. Proof of immunity to Rubella, Rubeola and Mumps, regardless of age

   □ **Documented history of 2 MMRs OR Documentation of positive Rubella, Rubeola, and Mumps titre**

2. Proof of TB skin test done within the last 12 months with negative results (complete the TB form included in this packet)

   □ **If TB skin test is positive, documented report of a negative chest x-ray must be on file. In addition, TB symptom survey must be on file and updated annually.**

3. Proof of immunity to Varicella

   □ **Documented history of 2 Varicella vaccines OR Positive Varicella titre OR Documented history (from a healthcare provider) of chicken pox or shingles**

4. Proof of full COVID vaccination or **approved** medical or religious exemption.

   □ **Documented history of vaccination**

5. Proof of influenza vaccination for the current influenza season for any observer who is in a DCMC facility for at least 1 day of their observation period between October 1 and March 31.

   □ **Documented history of annual influenza vaccines**

Date: _____ Name (Print) _____

Signature: _____

Reviewed by: _____

Renee Glesner RN, MSN

Door County Medical Center
IN PARTNERSHIP WITH HOSPITAL SISTERS HEALTH SYSTEM

## TUBERCULOSIS (TB) RISK ASSESSMENT QUESTIONNAIRE

Name (Printed): _____ Date of Birth: _____

Review the screening criteria and select all that apply. Provide explanations as indicated.

| |
|---|
| Recent TB symptoms: ☐ Yes ☐ No<br>a. Persistent cough lasting three or more weeks AND<br>b. One or more of the following symptoms: coughing up blood, fever, night sweats, unexplained weight loss, or fatigue.<br>If answered Yes: List the symptoms you are experiencing: _____ |
| Have you ever been treated with TB medication(s)? ☐ Yes ☐ No<br>If answered Yes: Med Name(s): _____<br>Duration of Medication(s): _____ |
| Have you ever been in close contact with someone with TB during your lifetime? ☐ Yes ☐ No<br>If answered Yes: Indicate the date(s): _____ |
| Birth, travel or residence in a country with high TB rates ☐ Yes ☐ No<br>Includes any country other than the United States, Canada, Australia, New Zealand or a country in Western or Northern Europe<br>If answered Yes: Indicate the date(s): _____ |
| Current/ former employee, volunteer or resident of a high-risk setting with an elevated TB rate ☐ Yes ☐ No<br>a. Includes Alaska, California, Florida, Hawaii, New Jersey, New York, Texas, or Washington DC<br>b. Includes correctional facilities, long-term residential care facilities, or shelter for the homeless<br>If answered Yes: Indicate the date(s): _____ |

By signing, I agree that to the best of my knowledge, that I do not have any of the above symptoms. I agree to notify the Infection Prevention Nurse if any symptoms of and/or exposures to Tuberculosis occur.

Signature: _____ Date: _____

**RETURN DOCUMENT TO THE INFECTION PREVENTION NURSE AS SOON AS POSSIBLE**

You will be contacted if further follow up is needed.

**For Use by Infection Prevention Staff:**

- ☐ A TB risk assessment was completed for individual named above. No risk factors for TB were identified.
- ☐ A TB risk assessment has been completed for the individual named above. Risk factors for TB have been
- ☐ Identified. Further testing recommended determining the presence or absence of tuberculosis in a communicable form.

Comments: _____

IP RN or Designee Signature: _____ Date: _____

Effective: 03-22-19 Revised: 03-22-19 Policy Medical/Infection Prevention/TB Screening of Positive Skin Tests

Renee Glesner RN, MSN

Door County Medical Center
IN PARTNERSHIP WITH HOSPITAL SISTERS HEALTH SYSTEM

# STUDENT CONFIDENTIALITY AGREEMENT

I, the undersigned, acknowledge that I have reviewed and understand the following information with regard to the confidentiality and access of patient protected health information, employee information, and proprietary information which I may work with during the course of my educational affiliation:

**General:**

- All patient, employee, and proprietary information is considered confidential and protected by law and failure to maintain confidentiality may result in damages to the patient, employee, and/or the healthcare organization.
- Access to patient, employee, and/or propriety information is determined by a "need-to-know" and held to the minimum-level of information necessary to carry out duties or assignments.
- Assignment of a computer system unique user ID and password is limited to individual use only, may not be shared, and may be audited to determine appropriateness of access.
- No patient protected health information, regardless of medium or format, shall be removed from the healthcare organization without the approval of the health care facility and the supervising educator. If such removal is approved, all patient-identifiable information must be removed or obliterated.
- Consequences of breach of confidential patient protected health information, be it intentional or not, will result in corrective action as deemed appropriate by the healthcare organization and educational institution.

Signed: _____ Date: _____

Printed Name: _____

Educational Institution/Program: _____

Approved By: _____ Date: _____

*Program Director/Clinical Instructor/ Site Supervisor*

Door County Medical Center
IN PARTNERSHIP WITH HOSPITAL SISTERS HEALTH SYSTEM

## True/False Questions

T◯ F◯ 1. The single most important measure for preventing the spread of infection is proper hand hygiene.

T◯ F◯ 2. Hands do not need to be washed before and after using gloves.

T◯ F◯ 3. Hazardous Waste refers to all wastes.

T◯ F◯ 4. Maintaining the confidentiality, privacy and security of patients' Protected Health Information (PHI) is not only a matter of organizational policies and procedures, but a right assured by federal HIPAA legislation and state laws.

T◯ F◯ 5. BRMH follows a no retaliation policy in regards to reporting harassment.

T◯ F◯ 6. Safety Data Sheets (SDS) are located "on-line" on the DCMC intranet page.

T◯ F◯ 7. Breaching patient confidentiality may be grounds for disciplinary actions up to and including discharge.

**FIRE SAFETY**

The RACE for fire safety stands for:

**R=**_____

**A=**_____

**C=**_____

**E=**_____

**FIRE-EXTINQUISER**

The PASS acronym stands for:

**P=**_____

**A=**_____

**S=**_____

**S=**_____

Door County Medical Center
IN PARTNERSHIP WITH HOSPITAL SISTERS HEALTH SYSTEM

**List Door County Medical Center's Values below:**

**1.** _____

**2.** _____

**3.** _____

**4.** _____

I have read the required orientation information as well as completing the Alternative Orientation Response Sheet. My signature below indicates my understanding of the core processes of Door County Medical Center as outlined in the handbook.

My signature additionally validates my intention to comply with the stated elements. If I have questions regarding any information, I am to contact a staff member.

I acknowledge receiving information on the policies and procedures related to confidentiality and the Security of protected health information required by the federal HIPAA Security rule. I understand that my use or disclosure of PHI is limited to the extent that the information is necessary to perform my assigned tasks and that unauthorized use or disclosure may result in termination of my time at Door County Medical Center.

Date: _____ Name (Print) _____

Signature: _____

Reviewed by: _____

Door County Medical Center
IN PARTNERSHIP WITH HOSPITAL SISTERS HEALTH SYSTEM

# Student Program Parental Permission Form

Date: _____

I hereby give permission for my son/daughter _____ to participate in the Job Observation Experience at Door County Medical Hospital. I certify that my son/daughter is _____ years of age and that his/her birth date is _____.

I also authorize any health screening that is required for participation in the Job Observation experience.

Name of Parent/Guardian: _____

Home Phone Work: _____

Phone Cell Phone: _____

Emergency Contact Information: _____

Renee Glesner RN, MSN

Save Form