



NORTH BROWARD HOSPITAL DISTRICT
d/b/a BROWARD HEALTH

OBSERVATIONAL EXPERIENCE PHYSICIAN AGREEMENT

_____, (physician name), being an active member of the medical staff in good standing at:

- Broward Health Medical Center/Broward Health Children's Hospital
- Broward Health North
- Broward Health Imperial Point, and/or
- Broward Health Coral Springs

do hereby request that said physician be authorized to sponsor said student for purposes of clinical observation and teaching at the one or more of these hospitals of which I am affiliated.

The physician and student understand that:

1. The physician will be solely responsible for providing the student with the opportunity to observe clinical practices within the limitations of physician's specialty and area of clinical expertise.
2. The student is allowed to observe only those patients of the sponsoring physician and only in the presence of said physician.
3. The student is not permitted to make any comments or recordations in the official medical record of any patient, nor is the student to order, in writing or verbally, any treatment, test, procedure, medication, etc., nor to render any diagnostic or clinical opinions.
4. In no case should confidential information be conveyed to individuals outside the organization, including family or associates, or even other facility employees or other health care team members who do not need the information in performing their job duties.
5. Authorization may be withdrawn at any time upon notice to the sponsoring physician and the student.

The school status of the student and the purpose(s) of the educational assignment are as stated in the attached documents. The student's period of observation with the physician will be from _____ to _____.

Dated this _____ day of _____, 20_____.

Physician's Signature
Printed Name: _____

Student's Signature
Printed Name: _____

APPROVAL:

Department Chief

Administrator