North Broward Hospital District, d/b/a Broward Health
Observers in Broward Health Hospitals – Request and Approval

Applicant's Name	
Phone Number	
Email Address	
Date of Birth	
Social Security Number	
License Number (if applicable)	
Type of License (if applicable)	
Hospital Location(s) Requested	☐ Broward Health Medical Center (including Salah Foundation Childrens Hospital) ☐ Broward Health Coral Springs (including Salah Foundation Childrens Hospital) ☐ Broward Health Imperial Point ☐ Broward Health North
Area/Department(s) Requested	
Physician Observing	
Physician Specialty	
Dates of Observation	
Reason for Observation	

Along with this form, you must also provide the following:

☐ Copy of your U.S. government-issued photo ID
☐ Copy of current, professional license, if applicable
☐ Copy of your current health insurance car
☐ Copy of negative TB test results or negative chest x-ray
☐ Completed Vaccine Statement
☐ Confidentiality and Data Security Agreement

Received by Medical Staff Administration by:

Region	Name	Title	Date
☐ BHMC ☐ BHCS ☐ BHIP BHN			

Approval by Medical Staff Representative and Senior Hospital Executive:

Region	Name	Title	Date
☐ BHMC ☐ BHCS ☐ BHIP BHN			
Dates of Approval:	From:	To:	
Conditions, if any:			

Distribution: ☐ Observer | ☐ Sponsoring Physician | ☐ Applicable Hospital Staff

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Observers in Broward Health Hospitals – Acknowledgement

The Observer and Sponsoring Physician(s) listed on this form understand that they will fully comply with the Broward Health Medical Staff Bylaws and applicable policies, as a condition of this opportunity. Medical Staff Administration will make available the Medical Staff Bylaws, Observer Policy, and Code of Conduct to the Sponsor and Observer prior to approval. As a condition of approval, the Sponsor and Observer understand and agree as follows:

1. Limit experience solely to observation at the specific facilities and times approved by Broward Health. Under no circumstances will Observer participate in, provide, or make any decisions relating to the evaluation, care, or treatment of any Broward Health patient. All decisions relating to the evaluation, care and treatment of each individual patient will be made solely by Broward Health physicians, nurses, or other authorized Broward Health personnel. This includes, but is not limited to, Observers not reviewing, writing in charts, or touching patients.
2. Abide by all policies, procedures, rules, and regulations of Broward Health.
3. Present and conduct himself/herself in a manner that is professionally and ethically appropriate and that does not interfere with or create any risk of harm to Broward Health, its patients, employees, agents, or any persons on Broward Health premises.
4. Maintain the absolute confidentiality of all information (whether in oral, electronic, or paper form) that Observer may have access to during his/her experience at Broward Health.
5. Reimburse and indemnify Broward Health for any damages or other injuries caused by Observer while participating in his/her observational experience at Broward Health.
6. Refrain from representing himself/herself as an agent, representative, or employee of Broward Health at any time. Observers should check in each day at the visitor's desk to obtain a visitor's pass, unless otherwise instructed. Visitor's pass should be prominently displayed at all times. Observers may not wear lab coats, jackets, or carry a stethoscope or any other medical evaluation equipment.
7. Assume all risks of, and be solely responsible for, any injury or illness, including medical care and treatment expenses, while participating in his/her observational experiences at Broward Health.
8. Vacate the premises if Broward Health determines that my observational experience is not in the best interest of its patients or personnel.
9. Assume the risk of possible exposure to hazards that could result in personal injury, illness, or death, among others.
10. I certify that I have received the Broward Health Medical Staff Bylaws, Observer Policy, and Code of Conduct, and will abide by all requirements, and I agree to be bound by the condition stated in this Agreement. Further, I understand that failure to comply will subject me to sanctions as determined by Broward Health's Administration and Medical Staff.

Observer Name	Title / Credential (if any)	Specialty (if any)	Date
Physician Sponsor	**Department**	**Specialty**	**Date**
Physician Sponsor's Signature			**Date**

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Observers in Broward Health Hospitals – Vaccine Statement

The Observer states as following regarding their current vaccination status:

INFLUENZA VACCINATION

I received the influenza vaccine during the 20___ - 20___ influenza season (October 1 through March 31).

☐ Yes: month/year received: _____. Proof of vaccine must be provided with application.

☐ No: ☐ afraid of needles ☐ religious belief ☐ afraid of getting the flu ☐ choose not to consent ☐ other reason

COVID-19 VACCINATION

Are you fully vaccinated against COVID-19? ☐ Yes ☐ No

(NOTE: Fully vaccinated means receiving a 2-dose series of a monovalent COVID-19 vaccine, OR a single does of Janssen, OR a single dose of bivalent vaccine.)

Or, decline to answer: ☐ Yes ☐ No

Observer Name	Title / Credential (if any)	Specialty (if any)	Date