

ALLEGHENY GENERAL HOSPITAL—WESTERN PENNSYLVANIA HOSPITAL
MEDICAL EDUCATION CONSORTIUM

RESIDENT OBSERVERSHIP APPLICATION

APPLICANT INFORMATION

Last Name _____ First Name _____ M.I. _____

Street Address _____ Apt. # _____

City _____ State _____ Zip _____

Gender ___ M ___ F Phone Number _____ Date of Birth _____

Emergency Contact _____ Relationship _____

Emergency Contact Phone _____

RESIDENCY PROGRAM INFORMATION

Current Residency Training Program: _____ Program Level _____

Sponsoring Institution Name: _____

Street Address _____

City _____ State _____ Zip _____

Program Director _____ Residency Coordinator _____

OBSERVERSHIP INFORMATION

Department where you will be observing _____

Site Sponsor's Name _____ Dates of Observership _____

REASON FOR OBSERVATION REQUEST (Please explain why you are interested in this observation opportunity)

Allegheny General Hospital Sponsor

Last Name _____ First _____ M.I. _____

Disclaimer and signature

By signing this application,

- I request consideration for a period of observation at Allegheny General Hospital.
- I understand that I will NOT be permitted to engage in patient care.
- At any time, I will not be asked or allowed to answer specific questions about a patient’s care or treatment, or otherwise provide medical or professional opinions.
- I understand that through my sponsor I will be expected to follow all of Allegheny General Hospital’s policies, rules and regulations, specifically those regarding infection control, safety and confidentiality.
- I agree to follow the directives of my sponsor. I understand that I must remain with my sponsor at all times.
- I understand that I am on Allegheny General Hospital property at my own risk and insurance coverage, that I will not be indemnified/insured by Allegheny General.
- I understand that if I breach any policies or obligations, my permission to act as an observer will be withdrawn and I may be asked to leave immediately.
- I certify that my answers are true and complete to the best of my knowledge. If this application is approved, I understand that I am responsible for submitting all required documents.
- **I am enclosing a copy of my current proof of PPD testing and a letter of good standing from my program director.**

Applicant Signature _____ **Date** _____

As program director, I approve of the above-named resident’s request to participate in an observership at Allegheny General Hospital.

Program Director’s Signature _____ **Date** _____

West Penn Hospital Sponsor

Last Name _____ First _____ M.I. _____

Disclaimer and signature

By signing this application,

- I request consideration for a period of observation at West Penn Hospital.
- I understand that I will NOT be permitted to engage in patient care.
- At any time, I will not be asked or allowed to answer specific questions about a patient’s care or treatment, or otherwise provide medical or professional opinions.
- I understand that through my sponsor I will be expected to follow all of West Penn Hospital’s policies, rules and regulations, specifically those regarding infection control, safety and confidentiality.
- I agree to follow the directives of my sponsor. I understand that I must remain with my sponsor at all times.
- I understand that I am on West Penn Hospital property at my own risk and insurance coverage, that I will not be indemnified/insured by West Penn.
- I understand that if I breach any policies or obligations, my permission to act as an observer will be withdrawn and I may be asked to leave immediately.
- I certify that my answers are true and complete to the best of my knowledge. If this application is approved, I understand that I am responsible for submitting all required documents.
- **I am enclosing a copy of my current proof of PPD testing and a letter of good standing from my program director.**

Applicant Signature _____ **Date** _____

As program director, I approve of the above-named resident’s request to participate in an observership at West Penn Hospital.

Program Director’s Signature _____ **Date** _____

**APPLICATION FOR RESIDENT OBSERVER AT ALLEGHENY GENERAL HOSPITAL
SPONSOR'S AUTHORIZATION AND ENDORSEMENT**

Service/Department _____

Start Date _____ **End Date** _____

OBSERVERSHIP SHOULD NOT EXCEED 2 CONSECUTIVE WEEKS

Sponsor Statement:

As an Allegheny General Hospital employee/or member of the Medical Staff with appropriate privileges for procedures, I endorse the applicant to complete the approved observership at Allegheny General. This applicant will be under my FULL supervision. I have reviewed the application and credentials submitted by this applicant to be a Resident Observer at Allegheny General. By my signature below, I agree to the following:

- I support the application and agree to personally oversee and supervise this individual during the approved period of observation.
- I will ensure the Resident Observer will abide by Allegheny General Hospital's policies, rules, regulations, and will review the hospital's rules for Patient Confidentiality, Safety Education and Standard Precautions.
- I understand that the Resident Observer is permitted only to view patient care, and only with patient consent. I agree that the Resident Observer will have no direct patient contact or provide any type of medical care.
- I will ensure the Resident Observer will wear his/her identification badge at all times while in the Hospital.
- I will ensure the Resident Observer will follow required hand washing practices while at the Hospital, specifically after using the bathroom, and upon entering or leaving a patient care area. The Resident Observer will not enter isolation rooms, and will not come to observe when he/she is sick, has a fever, or has been exposed to a contagious disease.

Last Name _____ **First** _____ **M.I.** _____

Specialty _____ **Office Phone** _____

Sponsor Signature _____

**APPLICATION FOR RESIDENT OBSERVER AT WEST PENN HOSPITAL
SPONSOR'S AUTHORIZATION AND ENDORSEMENT**

Service/Department _____

Start Date _____ **End Date** _____

OBSERVERSHIP SHOULD NOT EXCEED 2 CONSECUTIVE WEEKS

Sponsor Statement:

As a West Penn Hospital employee/or member of the Medical Staff with appropriate privileges for procedures, I endorse the applicant to complete the approved observership at West Penn. This applicant will be under my FULL supervision. I have reviewed the application and credentials submitted by this applicant to be a Resident Observer at West Penn. By my signature below, I agree to the following:

- I support the application and agree to personally oversee and supervise this individual during the approved period of observation.
- I will ensure the Resident Observer will abide by West Penn Hospital's policies, rules, regulations, and will review the hospital's rules for Patient Confidentiality, Safety Education and Standard Precautions.
- I understand that the Resident Observer is permitted only to view patient care, and only with patient consent. I agree that the Resident Observer will have no direct patient contact or provide any type of medical care.
- I will ensure the Resident Observer will wear his/her identification badge at all times while in the Hospital.
- I will ensure the Resident Observer will follow required hand washing practices while at the Hospital, specifically after using the bathroom, and upon entering or leaving a patient care area. The Resident Observer will not enter isolation rooms, and will not come to observe when he/she is sick, has a fever, or has been exposed to a contagious disease.

Last Name _____ **First** _____ **M.I.** _____

Specialty _____ **Office Phone** _____

Sponsor Signature _____