ALLEGHENY
GENERAL
HOSPITAL

APPLICATION TO OBSERVE AT ALLEGHENY GENERAL HOSPITAL

APPLICANT STATUS (Check one)

☐ Allied Health Student ☐ Medical Student ☐ Pre-Med Student ☐ Resident

☐ Licensed Independent Practitioner ☐ Other

APPLICANT INFORMATION

Last Name ______________________________ First Name _______________ M.I. _______

Street Address ____ Apt. # ______

City ____________________________________ State __________________ Zip _____________

Gender _____ M _____ F Date of Birth _____________________________________

Social Security Number ____

Most recent school attended ____

Graduation Date ____

Home Phone __________________________ Cell Phone ______________________________

Email ____

Emergency Contact _____________________________ Relationship ______________________

Emergency Contact Phone ____

Department where you will be observing ____

Preferred Dates ____

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

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Allegheny General Hospital Sponsor

Last Name ______________________________ First ________________ M.I. _______ Title _____

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- I understand that if I breach any policies or obligations, my permission to act as an observer will be withdrawn and I may be asked to leave immediately.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 CV, current proof of PPD testing, proof of malpractice insurance, current copy of your state license and one letter of recommendation from a peer.

Applicant Signature ____ Date __________________

Please submit application and fee of $300 to Susan Liebert, Medical Staff Office, Allegheny General Hospital, 320 E. North Avenue, Pittsburgh, PA 15212 (sliebert@wpahs.org). Checks should be payable to Allegheny General Hospital. Incomplete applications will not be accepted.

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SPONSORS AUTHORIZATION AND ENDORSEMENT

APPROVAL DATES

Service/Department ____

Start Date ______________________________ End Date ____________________

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 an 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 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 Observer is permitted only to view patient care, and only with patient consent. I agree that the Observer will have no direct patient contact or provide any type of medical care.
- I will ensure the Observer will wear his/her identification badge at all times while in the Hospital.
- I will ensure the 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 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.______

Title: ________________________

Street Address ____

City ____________________ State _______________ Zip _________________

Specialty _____________________Office Phone ____________________________

Email Address ____

Sponsor Signature ____

DO NOT WRITE BELOW THIS LINE – FOR INTERNAL USE ONLY

The applicant is approved ________ declined ___________

Dates of the observership (start and end)

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Division Director Signature Department Chair Signature

Date ____