



Allegheny General Hospital  
320 East North Avenue  
Pittsburgh, PA 15212-4772  
Tel 412.359.3131

## **OBSERVER POLICY FOR PHYSICIAN OBSERVERS MEDICAL STAFF OFFICE**

Physician observers are accepted by Allegheny General Hospital once a sponsoring physician on the medical staff of Allegheny General Hospital has been identified (the Medical Staff Office does not help in identifying the sponsoring physician), the observer has completed and signed the application for observership (attached) and has provided all accompanying documentation as listed below:

- Current CV
- Current proof of TB testing
- Proof of current malpractice
- Copy of current license
- One letter of recommendation from a peer

The observership period needs to be time limited (not more than one month) and a fee of \$300 paid prior to the beginning of the observership.

On the observer's first day, he/she will need an observer ID badge (Human Resources, 1<sup>st</sup> Floor South Tower) then meet with the sponsoring physician.

The sponsoring physician must also sign the observer application prior to the observer arriving at the Hospital. No benefits are given to the observer for this period of time.

**ALLEGHENY  
GENERAL  
HOSPITAL**

**APPLICATION TO OBSERVE AT ALLEGHENY GENERAL HOSPITAL**

**APPLICANT STATUS (Check one)**

- Licensed Independent Practitioner       Other

**APPLICANT INFORMATION**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_

Street Address \_\_\_\_\_ Apt. # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Gender      \_\_\_\_M\_\_\_\_F      Date of Birth \_\_\_\_\_

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 (not to exceed one month) 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 \$300 fee (payable to Allegheny General Hospital) to:**

**Allegheny General Hospital Medical Staff Office  
320 E. North Avenue  
Pittsburgh, PA 15212**

**Questions regarding the Shadow/Observer Program can be emailed to [Barb Amadio](mailto:Barb.Amadio@ahn.org) (Barb.Amadio@ahn.org).**

**Incomplete applications will not be accepted.**



## OBSERVATION DAY CONFIDENTIALITY AGREEMENT

I, \_\_\_\_\_, understand and agree that all information that I encounter during my observation day experience at an Allegheny Health Network facility or entity will remain strictly confidential.

I understand that the principles of confidentiality are applicable to all patients and to all medical record information regardless of the format or technology used to collect, store or release the information. I also understand that all verbal, written or electronic collection and dissemination of patient data will be conducted in a setting of maximum privacy precluding inadvertent disclosure.

I agree not to disclose any information that I may acquire during my observation experience at any Allegheny Health Network facility or entity unless previously authorized in writing by the system/facility/entity. Further, I agree that I will not use confidential information to my benefit or the benefit of any third party.

In addition to the confidentiality principles described above, I recognize that I am not an employee or agent of Allegheny Health Network and I will not represent myself as such during my observation experience at the system. I will not undertake any actions independently during my observation day experience.

I recognize that Allegheny Health Network has rules of conduct, behavior and personal health standards and I will be expected to conform to those rules that apply to my observation day.

I further understand that I will forfeit completion of the observation day if confidentiality is breached.

Signature below indicates understanding and acceptance of the contents of this statement.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature, Parent / Legal Guardian  
(Required if observer is less than 18 years of age)

\_\_\_\_\_  
Date