West Penn Hospital

West Penn Hospital
4800 Friendship Avenue
Pittsburgh, PA 15224-5000
Tel 412.578.5000

OBSERVER POLICY FOR PHYSICIAN OBSERVERS
MEDICAL STAFF OFFICE

Physician observers are accepted by West Penn Hospital once a sponsoring physician on the medical staff of West Penn has been identified (the Medical Staff Office does not help in identifying the sponsoring physician). The observer application and all accompanying documents listed below are required prior to the date requested.

- 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. The check should be made payable to West Penn Medical Staff and mailed to Barb Amadio, Medical Staff Office, 320 East North Avenue, Pittsburgh, PA 15212.

On the observer's first day, he/she will need an observer ID badge (Human Resources, 4th Floor North Tower – Phone 412-578-5043).

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.

WEST
PENN
HOSPITAL

APPLICATION TO OBSERVE AT WEST PENN 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)

_____

_____

West Penn Hospital

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 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 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 West Penn Hospital) to:

Medical Staff Office
320 E. North Avenue
Pittsburgh, PA 15212

Questions regarding the Shadow/Observer Program can be emailed to Barb Amadio (Barb.Amadio@ahn.org).

Incomplete applications will not be accepted.

OBSERVATION DAY CONFIDENTIALITY STATEMENT

I,_____, understand and agree that all information that I encounter during my observation day experience at _____(name of 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_____(entity) unless previously authorized in writing by the hospital. 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 _____(entity) and I will not represent myself as such during my observation experience at the hospital. I will not undertake any actions independently during my observation day experience.

I recognize that_____(entity) 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