

REQUEST TO OBSERVE PATIENT CARE - UF Health Science Center and Affiliated Entities

OBSERVER INFORMATION	Name:		Name and address of current institution, school, or employer
	Current Occupation:		
Type of Observers	<input type="checkbox"/> Visiting Scholar (clinical or otherwise) <input type="checkbox"/> Faculty/staff applicant (usually staying for a few days) <input type="checkbox"/> Student applicant <input type="checkbox"/> Other:		
Area(s) to Observe:	<input type="checkbox"/> Teaching Hospital <input type="checkbox"/> E.R. <input type="checkbox"/> O.R. <input type="checkbox"/> Other (clinic/institute name):		
Date Range	Starting by		Ending by
Reason(s) for Observation	<input type="checkbox"/> Visiting Health Care Provider <input type="checkbox"/> Career Planning <input type="checkbox"/> Required Course Work (describe below) <input type="checkbox"/> Other:		
UF Dept. Contact	Name:		E-mail:
	Department:		
Sponsoring Faculty Submitting Request	Name and Title:		Phone Number:
	College:	Department:	Division:
Observer attests to the following: <input type="checkbox"/> Completed HIPAA / Privacy General Awareness <input type="checkbox"/> Signed Confidentiality Statement <input type="checkbox"/> Will display an "observation ID badge" while observing <input type="checkbox"/> Has received a flu shot within the past calendar year or will "mask up" in patient care areas.			
Observer signature:			
Observer Statement of Interest. Please describe your reason(s) for requesting to observe care and how this experience will enhance your clinical knowledge. Attach a statement if necessary.			
Sponsoring Faculty Member specifically agrees that: <ul style="list-style-type: none"> ➤ Observer may not provide patient care, must be accompanied by UF/UFH staff, that patients have consented, and ➤ The Sponsoring Faculty Member assumes full responsibility for the actions of the Observer(s) and agrees to ensure that the Observer(s) complies with applicable UF / UF Health policies while observing care. 			
Signature of Faculty Member Sponsor:			Date of Request:
Approved by Dean of College or Designee (signature):	Date Approved:	Return completed form plus attachments to: Gainesville COM: Sr. Assoc. Dean Clinical Affairs at Observe-UFHealth@ufl.edu All Other Colleges: UF Privacy Office at privacy@ufl.edu	
Approved by UFH Shands Designee, if needed (signature):	Date Approved:		