As the applicant for this Clinical Observer/Educational Experience, I understand the following policies and agree to abide by them:
1. I recognize that as an unlicensed person I can only function as an observer.
2. I may participate in educational rounds, conferences and other Medical Education activities as directed by the responsible faculty.
3. I will maintain confidentiality and have signed the attached Confidentiality Agreement.
4. I may have patient contact within the following limits:
   • I will not do any physical examination of a patient;
   • I may verbally interact with a patient only with his/her approval and in the presence of a Senior Resident or Attending Physician who will be responsible for ensuring appropriate, professional and accurate communications;
5. I will not write in the medical record, although I may be given "mock" documentation exercises to practice documentation and have my skills assessed outside of the official medical record. I understand that I must receive instruction on aseptic technique and that during surgery or any procedure, I may not be near the surgical field or table, but may observe the activity with other members of the team. I will follow the directions of the physician or supervising nurse.
6. I have obtained sponsorship by a Sparrow Hospital, Affiliated Residency Program or Medical Staff Member as indicated by the Residency Program Director's Signature below.

As the **applicant** I have read, understand and agree to the above conditions of participation in this Clinical Educational Experience.

Applicant Signature

Date

Local telephone/pager number where I can be reached during this experience:

As the **Residency Director** of the Program or **Medical Staff Member** sponsoring Clinical Observer/Educational Experience, I verify:

- the individual has met the criteria to participate in this Clinical Observer/Educational Experience
- the program has the process in place to monitor the individual's performance
- this observer is introduced to patients appropriately and there are no objections
- the program has established supervision consistent with this policy.

Authorized Signature (Residency Director or Medical Staff Member)  

Date

Director of Medical Education

Date

*Note: To be used when the "Observer" is with a physician and is not necessary when general approval is given for an event such as "Bring your child to work day".*

G:\Users\MED_ED\SYS_OPR\MSWORD\Forms\ClinicalObserver.doc
As an associate, physician, healthcare provider, contractor, temporary employee or volunteer of a Sparrow Health System entity, you may have access to confidential information including patient, financial or business information obtained through your association with Sparrow Health System. The purpose of this Acknowledgment is to help you understand your personal obligation regarding confidential information.

Confidential information includes any information about a person’s past, present, or future physical or mental health; the health care services provided to the individual or payment information related to such services, that identifies the individual or provides enough information that there is a reasonable basis to believe the information could be used to identify the individual.

Confidential information is valuable and sensitive and is protected by law and by strict Sparrow Health System policies. State law and the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), require protection of confidential health information. Inappropriate disclosure of confidential health information regarding patients may result in the imposition of fines on Sparrow Health System of up to $250,000 and ten years imprisonment per incident.

Accordingly, by signing this Acknowledgement and, having as a condition of and in consideration of my access to confidential information whether in oral, paper, electronic, or any other form, I acknowledge the following obligations and conditions of employment:

1. I am only allowed to access confidential information for which I have a legitimate need to know as part of my job responsibilities at Sparrow Health System and am only allowed to access information systems for which I am an authorized user. I am prohibited from removing any confidential information from Sparrow premises in any media including paper, magnetic disk, compact disk, video, recording, etc. without the express written permission of an authorized officer of Sparrow Health System. In addition, if I have remote access to Sparrow Health System information systems, I will not download or transfer any confidential files or data to my home personal computer.

2. I am prohibited from using or connecting to the personal computer assigned to me by Sparrow Health System, any equipment, modem, other hardware, or software without the prior written approval of Sparrow Health System Network & Infrastructure – Information Services.

3. I am allowed only to access the Internet through the Sparrow Health System computer network firewall. I am prohibited from utilizing dial out modems or other means to access the Internet.

4. I am prohibited from discussing confidential information in any location at Sparrow Health System where it is likely that the conversation can be overheard by people who do not have a legitimate need to know the confidential information in order to perform their job responsibilities at Sparrow. I am required to return all recorded confidential information to its authorized, secure location in Sparrow Health System when I am done with it. I am prohibited from in any way divulging, copying, releasing, selling, loaning, reviewing, altering or destroying any confidential information unless expressly permitted by existing policy or as properly approved in writing by an authorized officer of Sparrow Health System within the scope of my association with Sparrow Health System.

5. I am prohibited from utilizing another person’s password in order to gain access to any information system. I am prohibited from revealing my computer access code to anyone else unless a confirmed request for access to my password has been made by Information Services and I am able to confirm the legitimacy of the request and the requestors. I am required to change my password immediately after it is disclosed to anyone. I am personally responsible for all activities occurring under my password.

6. If I observe or have knowledge of unauthorized access or divulgence of confidential information I am obligated to report it immediately to my supervisor or to I.S. Information Security.

7. I am prohibited from seeking personal benefit or permitting others to benefit personally by any confidential information that I may have access to.
SPARROW HEALTH SYSTEM
Acknowledgement of SHS Confidentiality and Security Obligations and/or Conditions

8. I acknowledge and recognize that I am prohibited from operating any software on the personal computer assigned to me by Sparrow Health System, other than those programs provided to me by Information Services, without the prior written approval of my supervisor.

9. I acknowledge that all information, regardless of the media on which it is stored (paper, computer, videos, recorders, etc.), the system which processes it (computers, voice mail, telephone systems, faxes, etc.), or the methods by which it is moved (electronic mail, face to face conversation, facsimiles, etc.) is the property of Sparrow Health System and shall not be used inappropriately or for personal gain. I also acknowledge that all electronic communication shall be monitored and subject to internal and external audit.

10. I acknowledge that my failure to fulfill the obligation or conditions in this Acknowledgment may result in disciplinary action, which might include, but is not limited to, termination of employment or, loss of my privileges within Sparrow Health System or other legal action.

By my signature below, I acknowledge that Sparrow Health System has an active on-going program to review records and transactions for inappropriate access and I acknowledge that inappropriate access or disclosure of confidential information contrary to or inconsistent with the conditions described in this acknowledgement can result in penalties up to and including termination of my employment and/or legal action against me.

________________________  __________________________
Signature                Date

________________________
Printed Name