

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

<b>OBSERVER INFORMATION</b>	Name:		Name and address of current institution, school, or employer
	Current Occupation:		
<b>Type of Observers</b>	<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:		
<b>Area(s) to Observe:</b>	<input type="checkbox"/> Teaching Hospital <input type="checkbox"/> E.R. <input type="checkbox"/> O.R. <input type="checkbox"/> Other (clinic/institute name):		
<b>Date Range</b>	Starting by		Ending by
<b>Reason(s) for Observation</b>	<input type="checkbox"/> Visiting Health Care Provider <input type="checkbox"/> Career Planning <input type="checkbox"/> Required Course Work (describe below) <input type="checkbox"/> Other:		
<b>UF Dept. Contact</b>	Name:		E-mail:
	Department:		
<b>Sponsoring Faculty Submitting Request</b>	Name and Title:		Phone Number:
	College:	Department:	Division:
<b>Observer attests to the following:</b> <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.			
<b>Observer signature:</b>			
<b>Observer Statement of Interest.</b> Please describe your reason(s) for requesting to observe care and how this experience will enhance your clinical knowledge. Attach a statement if necessary.			
<b>Sponsoring Faculty Member specifically agrees that:</b> <ul style="list-style-type: none"> <li>➤ Observer may not provide patient care, must be accompanied by UF/UFH staff, that patients have consented, and</li> <li>➤ 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.</li> </ul>			
Signature of Faculty Member Sponsor:			Date of Request:
<input style="width: 100%;" type="text"/>			
Approved by Dean of College or Designee (signature):	Date Approved:	<b>Return completed form plus attachments to:</b> <b>Gainesville COM:</b> Sr. Assoc. Dean Clinical Affairs at <a href="mailto:Observe-UFHealth@ufl.edu">Observe-UFHealth@ufl.edu</a>  <b>All Other Colleges:</b> UF Privacy Office at <a href="mailto:privacy@ufl.edu">privacy@ufl.edu</a>	
Approved by UFH Shands Designee, if needed (signature):	Date Approved:		