Appendix A

UC Health Observation Request Form Return all documents to:
Department of Education: education@uchealth.com
Phone: 513-585-5320

Name _____ Date of birth _____

Email _____ Phone _____

Number of Days Observing: _____ Reason for Visit: _____

Requested Start Date(s): _____ * End Date: _____

Observations are limited to 30 clinical days. Badge card will indicate expiration date above or 30 days after issue, whichever is shorter. Extensions after 30 days require new badge card authorization from Vice President of Education.

Sponsoring Staff Member: Michael J. Grau, Jr., DMD

Contact Person Name: Yvonne Hawkins Phone / E-Mail: 584-2589/hawkinye@ucmail.uc.ed

All activities of the observer are to be performed in conjunction or in consultation with the sponsor or in conjunction or in consultation with the sponsor's designee.

Unit(s) where Observation will occur:

- Hospital Unit or Procedure Area : Holmes Hospital
- Hospital Clinic: Holmes Hospital
- Location: 200 Albert Sabin Way Cincinnati, Ohio 45219

I approve observation of this applicant for the time period stated above.

Signature of Responsible Manager _____ Printed Name _____ Date _____

The following are required and must be attached:
Attach a copy of the following:

- ☐ Observation Request Form (Appendix A)
- ☐ TB Attestation/TB test results within previous 12 months
- ☐ Consent and Release (Sponsoring Staff) (Appendix B)
- ☐ Consent and Release (Observer) (Appendix C)
- ☐ Signed Confidentiality Statement (Appendix D)
- ☐ Consent and Release (Parent or Legal Guardian - if applicable) (Appendix E)
- ☐ Copy of Government Issued Photo ID/Passport
- ☐ Evidence of seasonal flu vaccine if observation request between October (10/01) and March (3/31)

Approved: _____ _____
Signature of UC Health Department of Education Date

Department Name for Badge: _____

Appendix B

UC Health TB Attestation

Domestic Observers Only

Tuberculosis/Travel:		**Yes**	**No**
A	I do not have unexplained fever, night sweats, shortness of breath, cough, or weight loss.		
B	Have you spent time with a person known to have active TB or suspected to have TB disease?		
C	I have had a "positive" tuberculin skin test (e.g., PPD) in the past.		
D	I have taken anti-tuberculosis medications (e.g., INH) in the past		
	If Yes to C or D above, when was your last chest x-ray?		
E	Have you traveled to or had visitors/family members' travel to/from the Arabian Peninsula in the past three weeks?		
F	Have you traveled to a country where TB disease is common for more than a 2 week period (e.g., Latin America, Caribbean, Africa, India, China, Southeast Asia, Eastern Europe, or Russia)?		
G	Work/Volunteer with those in need where TB disease is more common: Homeless shelter, migrant farm camp, prison or jail and some nursing homes?		
H	Have you had visitors from countries where TB disease is common (most countries in Latin America and the Caribbean, Africa, India, China, Southeast Asia, Eastern Europe, and Russia) living in your home for more than 2 weeks?		

By signing below, I acknowledge that I have truthfully answered the questions above. By signing below, I acknowledge that, for the health and safety of UC Health patients, visitors, and personnel, I should not participate in UCH activities if I have symptoms of a communicable disease (e.g., fever, cough, or rash illnesses) until those symptoms have resolved.

_____ _____

Signature Date

_____

Printed Name

Appendix C

UC Health Required Immunization Form for Observers

Name _____DOB_____

The UC Health requires that all observers at UCH show proof of testing for tuberculosis (international only) and of immunity to measles, mumps, rubella, varicella, and tetanus/ diphtheria/pertussis. Observers must be free from infectious diseases at the start of the observation. Any observer who becomes ill with a communicable disease during participation as a observer is REQUIRED to notify their sponsoring staff, and remove himself/herself from patient care observations.

Please date the following that have been completed by the above named International Observer:

_____ TB SKIN TEST (Mantoux): Past two annual test dates required or 2-step testing, most recent test MUST be within 12 months of rotation start date OR QUANTIFERON - International Observers Only

_____ Tetanus/Diphtheria/Pertussis: TDaP booster within the last 10 years.

_____ MMR (measles, mumps, rubella): 2 Vaccines or Positive Serology

_____ Varicella: 2 doses of vaccine at least 4 weeks apart or serologic evidence of immunity.

Observer Signature: _____Date: _____

Provider Signature: _____Date: _____

Appendix D

Consent and Release (Observer)

In requesting approval for observation of patient care at Holmes Hospital/UC Medical Center, I expressly accept these conditions during the processing and consideration of my request, and throughout the observation period.

1. I understand and agree that I have the burden of producing adequate information for proper evaluation of my qualifications or any other matter that might directly or indirectly have an effect on patient care or the orderly operation of the facility to which I am seeking access.

2. I certify I'm free from communicable diseases, and that within 24 hours of a request by UC Health personnel I can provide evidence that I am free of active tuberculosis (as shown by PPD skin testing or chest X-ray), immune from hepatitis B (or declined in writing to be immunized against hepatitis B), immunized against influenza (annually), and is either immune from or has been immunized against rubella, mumps, measles, and varicella (chicken pox).

3. I understand and agree to the requirements in the UC Health **CONFIDENTIALITY AND DATA SECURITY AGREEMENT for Contractors and Non-employees. (Appendix F)**

4. I understand that additional observation to the unit or area may be required by the hospital unit manager. I agree to meet any additional requirements as needed.

5. I understand that the management of the hospital has the right to revoke permission for observation at any time, and agree that I will immediately leave the Patient Care Area if requested to do so.

6. I hereby release UC Health, LLC, University of Cincinnati Medical Center, LLC, West Chester Hospital, LLC, Daniel Drake Center for Post-Acute Care, LLC, University of Cincinnati Physicians Company, LLC, Drake Development, LLC (doing business as Bridgeway Pointe), their respective directors, officers, agents and employees, and any third parties (including but not limited to all individuals, government agencies, organizations, associations, partnerships, corporations, limited liability companies or other entities, whether hospitals, insurers, or health care facilities) from any and all civil liability that may arise from my activity at the facility to which I am seeking access during my observation period. This includes but is not limited to any liability for exposure to infectious agents or development of any illness that might be attributable to my activity at the facility to which I am seeking access.

7. I hereby represent that I have voluntarily signed this Consent and Release; and, that I have no questions regarding the content herein.

_____ _____

Signature **Date**

_____ _____

Printed Name **Date of Birth**

Appendix E

Consent and Release (Sponsoring Staff)

Visiting Observer: _____

Date of Visit: _____

Facility and Location where Observation will take place: Holmes Hospital/ UC Medical Center

1. I agree that I have the primary responsibility of supervision of the observer's activities during the duration of the visit. I agree to abide by all hospital and departmental policies and procedures related to observation of patient care.

2. I agree to obtain informed consent of the patient to include agreement to observation by the visitor.

3. I understand that requests from individuals under the age of 18 will be evaluated by the manager of the area to be observed on a case-by-case basis. Parent/Guardian consent must be obtained.

4. I understand that individuals who are observers are not permitted to scrub for operative procedures, or operate equipment or otherwise participate in patient care.

5. I hereby release UC Health, LLC, University of Cincinnati Medical Center, LLC, West Chester Hospital, LLC, Daniel Drake Center for Post-Acute Care, LLC, University of Cincinnati Physicians Company, LLC, Drake Development, LLC (doing business as Bridgeway Pointe), their respective directors, officers, agents and employees, and any third parties (including but not limited to all individuals, government agencies, organizations, associations, partnerships, corporations, limited liability companies or other entities, whether hospitals, insurers, or health care facilities) from any and all civil liability that may arise from my sponsorship of the visitor listed above. This includes but is not limited to any liability for exposure to infectious agents or development of any illness that might be attributable to the activity of the visitor listed above.

_____ _____

Signature of Sponsoring Staff **Date**

_____

Printed Name

Requirements of All UC Health Contractors or Non-Employees Regarding PHI and Confidential Information

The services provided by UC Health for its patients and other customers are highly confidential and must not be released or discussed with unauthorized persons. There are both Federal and State Laws that safeguard the privacy and confidentiality of PHI and other confidential information from unauthorized access, use or disclosure. I understand that by signing this agreement, there may be legal, ethical, and personal ramifications for violating its terms.

Confidential information includes, but is not limited to, information about a patient's condition, treatment or payment for services, aggregate clinical data, employee records, processes, marketing plans or techniques, product or service plans, strategies, forecasts, customer/patient lists, supplier lists, discoveries, ideas, pricing policies and financial information. This confidential information can be obtained through a variety of means including seeing or hearing it, access to computer systems or access to PHI in paper form or in the electronic medical record.

Contractor or Non-Employee Agreements Regarding Use of PHI, Confidential Information and the Internet

- I agree to abide by UC Health HIPAA policies on privacy and confidentiality of PHI.
- I agree to access, use or disclose only PHI for which I am authorized through my work for or associated with UC Health and as complies with UC Health HIPAA policies. I agree not to invade patient privacy by examining PHI or data for inappropriate review.
- I agree not to discuss PHI in unauthorized areas such as hallways, elevators and cafeterias, where it could be overheard.
- I agree not to make unauthorized disclosures, copies or transmissions of PHI in any form including electronic transfer of PHI to personal devices.
- I understand that any access to PHI for research purposes requires proper documentation and approval according to HIPAA policies.
- If given a system password(s) to use, I agree to keep it (them) confidential and not share it (them) with any individual or allow any individual to access information through my password(s). I understand that giving a password to an unauthorized individual may result in disciplinary action up to and including contract or account access termination.
- I understand my password(s) may identify information that I have accessed, which may be monitored and audited
- I understand my password(s) may be changed periodically to help maintain the security of UC Health.
- I understand that I must safeguard data at all times – during its origin, entry, processing, distribution, storage and disposal. This includes data in electronic, paper, film, video or other forms.
- I understand that I must safeguard data from unauthorized access (accidental or intentional), modification, destruction or disclosure.
- I understand that data used in business and clinical operations is an asset of UC Health.
- I understand that e-mail is the property of UC Health and its member institutions and may be monitored. I further understand that I should have no reasonable expectation of privacy when using UC Health e-mail or Internet.

- I understand that, should I have access to the Internet, it is provided by UC Health to assist in completion of work assignments (i.e. patient care, research, education). I understand that this access should be considered an extension of my work environment.
- I understand that the use of unlicensed or unapproved software constitutes a serious risk to UC Health operations and I further agree not to install or use any software without obtaining proper approval from IS&T Information Security.
- I understand that upon my contract termination or end of work with UC Health, my ability to access UC Health information will end. I agree that I will not attempt to access the systems or disclose any confidential information and/or PHI to any person or entity at that time.
- I understand at the termination of my contract or end of work with UC Health, I will return any confidential information including PHI that is in my possession, to UC Health.
- I understand I must continue to honor all of the obligations mentioned above after termination of my contract or end of work with UC Health.
- I understand that UC Health reserves the right to immediately terminate my access to electronic medical records if there is inappropriate access to PHI.
- I understand the use of interconnect functionality, e.g. Epic Care Everywhere, to retrieve or access PHI from non UC Health hospitals for the purposes of research study participant recruitment is strictly forbidden. Interconnect functionality is limited to treatment, billing, or healthcare operations.
- I understand that unauthorized access, use or disclosure may have serious legal repercussion for me and/or my employer.
- I understand unauthorized access, use or disclosure of PHI may subject me and/or UC Health to Federal and State fines and penalties
- I understand that access to PHI for illegal purposes will subject me to prosecution to the fullest extent of the law.

I have read this document and understand that my signature constitutes my acceptance of the terms of this agreement and that a violation of it can result in disciplinary action, up to and including termination of my contract or relationship with UC Health and/or termination of my access to UC Health electronic systems including the electronic medical record. I also recognize that by signing this agreement, there may be serious legal, ethical and personal consequences for violating its terms.

_____ _____

Name (Print) Organization (Print)

_____ _____

Signature Date of Signature

_____

Date of Submission or Receipt

Appendix G

Consent and Release (Parent or Legal Guardian)

I, _____, certify and agree to the following:
[*printed parent or legal guardian name*]

1. My child/ward named below has my permission to participate in a job shadowing experience at the following UC Health facility or facilities: _____.

2. I understand that the terms and provisions of UC Health's *Consent and Release (Observer)* and *Confidentiality and Data Security Agreement* shall be incorporated herein by reference. I consent to this Consent and Release and to the incorporated terms and provisions on behalf of myself and my child/ward. I certify that I have explained all such terms and provisions to my child/ward and both I and my child/ward shall abide by them.

3. I certify that my child/ward is free from communicable diseases, and that within 24 hours of a request by UC Health personnel I can provide evidence that he/she is free of active tuberculosis (as shown by PPD skin testing or chest X-ray), immune from hepatitis B (or declined in writing to be immunized against hepatitis B), immunized against influenza (annually), and is either immune from or has been immunized against rubella, mumps, measles, and varicella (chicken pox).

4. I understand that job shadowing could include observing patients and/or medical, laboratory, and business procedures in a healthcare setting. I understand that UC Health facilities offer medical services for the care and treatment of a wide range of illnesses, diseases, and injuries, including but not limited to infectious diseases such as tuberculosis, hepatitis, and HIV. I understand that there is a risk that my child/ward could inadvertently be exposed to such diseases while participating in the job shadowing experience.

5. In the event of a medical emergency, I understand that while every attempt will be made to contact me before medical action is taken, I nonetheless consent to any emergency treatment or procedure deemed by UC Health staff to be necessary for my child/ward's health or wellbeing.

6. On behalf of myself and my child/ward, and to the maximum extent permitted by law, I assume all risks and liabilities associated with my child/ward's participation in the job shadowing experience, and I hereby release, discharge, and relieve UC Health, LLC, University of Cincinnati Medical Center, LLC, West Chester Hospital, LLC, Daniel Drake Center for Post-Acute Care, LLC, University of Cincinnati Physicians Company, LLC, Drake Development, LLC (doing business as Bridgeway Pointe), their respective directors, officers, agents and employees, and any third parties (including but not limited to all individuals, government agencies, organizations, associations, partnerships, corporations, limited liability companies or other entities, whether hospitals, insurers, or health care facilities) (collectively, the "Indemnitees") from any and all civil liability that may arise from my child/ward's participation in the job shadowing experience. This includes but is not limited to any liability for exposure to infectious agents or development of any illness that might be attributable to the activity of my child/ward named below. Furthermore, I agree to indemnify, defend, and hold harmless the Indemnitees from and against any and all actions, claims, lawsuits, or proceedings and all resulting damages, liability, costs and expenses (including attorneys' fees) related to the acts or omissions of my child/ward or the breach by me or by my child/ward of this Consent and Release or any incorporated terms and provisions.

Printed name of child/ward: _____ **Date of Birth:** _____

_____ _____

Signature of Parent or Legal Guardian **Date**

Appendix H

Infection Control Guidelines

The following information is required to be read by any individual requesting permission to observe patient care.

Hand Hygiene Highlights:

- Hand hygiene is a general term that applies to either the use of a waterless, rinse less alcohol-based hand rub for routinely decontaminating hands or hand washing.
- Alcohol hand rubs are the primary means of hand hygiene in the hospital setting. Use alcohol hand rubs between all patient contact and after removing gloves. Hands should be thoroughly washed with soap and water if visibly soiled and after every contact with blood or body fluids. Difficile.
- Gloves should be worn as a barrier to touching body fluids or contaminated objects.
- Do not wear gloves for clean activities such as touching the telephone, charting, retrieving supplies, etc. Do not wear gloves outside of patient rooms.
- Only natural fingernails are permitted for any caregiver providing direct "hands-on patient care. Natural nails are to be neatly manicured and natural nail length not to exceed ¼ inch. The only enhancement permitted to natural nails is unchipped fingernail polish.
- Personal hand lotions brought from home are not permitted in patient care areas. Lotions that contain petroleum or other oil emollients affect glove integrity and certain lotions may affect the persistent activity of alcohol-based hand rubs or antimicrobial soaps used in the hospital.

Blood-Borne Pathogens

Blood-borne pathogens are microorganisms present in the human blood and capable of causing disease in humans. This includes, but is not limited to, Hepatitis B Virus (HBV), Hepatitis C Virus (HCV), and Human Immunodeficiency Virus (HIV), the cause of AIDS.

HIV HBV and HCV can be transmitted in blood and the following body fluids:

- Pericardial fluid (around the heart)
- Peritoneal fluid (abdominal cavity)
- Semen
- Vaginal Secretion
- Synovial fluid (around the joints)
- Cerebrospinal fluid (around the brain & spinal cord)
- Amniotic fluid (around the baby)
- Breast milk

Transmission occurs when a person has contact with these body fluids via:

- Sexual contact
- Sharing needles
- Across the Placenta (mother to fetus during pregnancy)
- Needle stick injury
- Mucous membrane exposure (eyes, nose, mouth)
- Prolonged contact with non-intact skin
- Blood transfusion prior to 1985

Unless blood is present, HIV and HBV are not transmitted via: (a) Feces, (b) Urine, (c) Saliva, (d) Tears, (e) Vomitus, (f) Nasal secretion, (g) Sputum

Standard Precautions (Mandated by OSHA in 1991 and Ohio Law House Bill #419 AIDS and Hepatitis B law in 1993)

Standard Precautions assumes that all patients could have a contagious disease and require that health care workers use protective barriers to prevent contact with any blood or body fluid. All blood and body fluids from all patients should be treated as infectious because patients with blood borne infections may not have current symptoms or even know that they are infected.

Personal Protective Equipment (PPE)

PPE is easily accessible and provided by the hospital at no cost to the employee for use when the potential for biohazardous, radiation, or other occupational exposure exists. All equipment is cleaned, laundered, disposed of, repaired, or replaced as needed to maintain effectiveness at no cost to the employee.

The manager in the area you will be observing will notify you of the requirement to wear appropriate Personal Protective Equipment.

Gloves: are worn when it can be reasonably anticipated that the employee may have contact with blood, non-intact skin (rash) or other potentially infectious material and into Contact Isolation rooms.
Gowns: Protective gowns are impervious to saturation from blood and body fluids. Gowns are worn during procedures with the potential for exposure and into Contact Isolation rooms if substantial contact with the environment is anticipated.
Masks and Eye Protection: Mask and eye protection are worn during procedures that may generate a splash, spray and splatter of blood to the face, eyes, nose or mouth. Corrective eyeglasses are not appropriate eye protection. Use hospital eye protection. Surgical masks with eye protection are also required in rooms under Droplet Precautions. N95 masks are required for Airborne Isolation.
Sharps Disposal: Sharps are defined as any object that can penetrate the skin, including needles, scalpels, glass slides, glass test tubes, razors, etc.
Resuscitation Masks: are available in all patient care areas to minimize the need for mouth-to-mouth resuscitation.

Tuberculosis

Tuberculosis, or TB, has emerged as a major public health threat in the US. We follow the Center for Disease Control, State of Ohio, and Hamilton County TB Control recommendations, including testing of individuals in close proximity to patients. This is the reason for our requirement that you provide documentation of TB testing within the past 12 months. Individuals with known or suspected TB are isolated in Airborne Precautions rooms with negative air pressure. You must follow hospital policy when entering these rooms.

Radiation Safety

The radiation warning sign is posted where sources of ionizing radiation are present. Radiation generating equipment is labeled with this sign at the control panel. Any visitor who will be observing in an area with radiation-producing devices or where radioactive materials are present must inform the hospital Radiation Safety Officer.

Life Safety

This refers to the hospital's plans and preparation to protect patients, staff, visitors and its facilities and equipment from fire, smoke and other products of combustion.

Fire Safety

- Dial 3333 to report a fire
- Remember RACE - Rescue, Alarm, Confine, Extinguish or Evacuate in the event of a fire in your area
- Take time to identify the fire exits and fire extinguishers in any area.
- In the event of a fire alarm, you will hear an alarm and overhead announcement "Code d RED" with the location of the fire alarm.
- You must respond if the area is adjacent within one floor above or below in the same fire containment area. Follow experienced staff to the nearest exit if an evacuation is to occur.