

Wellstar MCG Health Observership Instructions

1. When contacted by a potential observer, please assess whether the individual is eligible. As defined by Policy 15.03, observers are “undergraduate and post-graduate students, clinicians in private practice and students participating in a Hospital-Administration endorsed program.”
 - a. If eligible, proceed to Step 2.
 - b. If not eligible, please refer to appropriate departments:
 - i. Refer vendors to Materials Management (706-721-9066)
 - ii. Refer volunteers to Volunteer Services (706-721-3596)
2. Obtain current Observership paperwork from Policy Tech at: <https://augusta.policytech.com/> and complete forms A-E:
 - a. All highlighted areas on forms A-E, found within brackets, must be replaced with actual information - unless they are not applicable to your request (i.e. approval for OR), in which case you may delete or identify the non-applicable text.
 - b. All highlighted areas on forms A, B and C, indicating signature and date, must be circulated for signature among the appropriate parties including the Director/Clinical Service Chief or/Chairman of the Department, **and** the person assuming supervisory role for the observer. If a Resident is the supervisor, he/she must also have an Attending Physician sign form C.
3. Submit the completed packet to Mary Tipton for Dr. Coule’s approval, 706-721-7348.mtipton@augusta.edu
 - a. Memo and Forms A-E (completed and signed by department officials)
 - b. Proof of a negative PPD or reading of chest x-rays within the last **12 months**
 - c. Proof of Influenza vaccine from October 1st to March 1st.
4. Once approved, an ID badge request will be sent to the JagCard office and the observer will need to get the ID Badge before the observership starts.
5. After the ID badge has been obtained, the Observer will also need to contact the Parking Office to obtain a parking hangtag.
6. Observer is now authorized to begin Observership.
7. Observerships are limited to a period of thirty days (30) unless special circumstances are described and approved by the Chief Medical Officer in advance of the starting date of the observership.
8. The Medical Center has the right to terminate an Observership if there is failure to comply with the terms of the agreement or interference with clinical operations.

NOTE: IF THE OBSERVATION INCLUDES OPERATING ROOM OBSERVATIONS, NUMBER 9 APPLIES

9. **OR Observations:** If the supervising physician is allowing the approved observer to observe patient care under his/her supervision in the OR, the observer **MUST** complete the “Operating Room Observership Orientation” page (Form E) included in this packet. Observers in the operating room must be 17 years of age or older.
10. Observership ID badge is required per policy –

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Once approved, Dept contact:

Name: _____

Telephone # _____

Required:

PPD: _____

Flu Vaccine: _____

(Required Oct 1 to Mar 1)

TO: Phillip L. Coule, MD, MBA, FACEP, FAEMS
VP AND CMO, Wellstar MCG Health

THROUGH: Kimberly Basso, RN, MSN _____ (sig)

Director, Pediatric Patient Care Services

Children's Hospital of Georgia

**(Approval required for all Pediatric/CHOG observerships, with exception of MD's-
otherwise delete)**

Valera Hudson, MD _____ (sig.)

Chair of Pediatrics

**(Approval required for Pediatric/Children's Hospital of Georgia observerships. If observer is
An MD – otherwise delete)**

FROM: "[Director, Clinical Svc., Chief or Chairman's Name]" _____ (sig.)

"[Director Clinical Svc. Chief, or Chairman's Title]"

"[Department Name]"

SUBJECT: Approval Request for "[Observer's Name]"

DATE: "[Date Submitted for Approval]"

This memo is to request approval for an observership, under the supervision of _____
during the period of "[Dates of Observership – generally no longer than 30 days]."

The purpose of this observership is to observe patient care in the Department of "[Department Name]" and Operating Room
(Delete if not observing in OR) at Wellstar MCG Health. I understand that an observership allows for an educational
process to occur in the clinical setting, however, it **does not** allow the observer to participate in activities which involve the
touching of patients, writing on the medical record, writing orders for patients, and/or answering questions posed by
patients or other care-providing staff regarding the treatment of patients.

Approved By:

Phillip L. Coule, MD, MBA, FACEP, FAEMS
VP Medical Affairs & CMO, Wellstar MCG Health

Date _____

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OBSERVERSHIP

Release & Waiver of Liability

FORM A

I, "[Observer's Name]", wish to observe the activities of the Department of "[Department Name]" and Operating Room (**Delete if not observing in OR**) at Wellstar MCG Health during the period of "[Dates of Observership]", in furtherance of my personal development and educational goals. **I understand that I will not be allowed to perform any clinical activities or other work, to include the touching of any patient, documenting on any medical record, and advising other care providers or patients.** I further understand that I will be under the supervision of "[Supervisor's Name]" and the chief housestaff physicians, and I am not to be in any patient care area without one of them being present with me. I understand that if I breach this agreement, it will result in immediate termination of my observership.

I understand that even though I will only be observing activities in the Department of "[Department Name]" and Operating Room (**Delete if not observing in OR**) at Augusta University and Wellstar MCG Health, I may be exposed to certain risks of bodily injury and other dangers, including but not limited to, exposure to blood borne pathogens, biological waste, and dangerous chemicals. I am aware of these risks and voluntarily assume these risks.

For and in consideration of Augusta University and Wellstar MCG Health allowing me to observe the activities in the Department of "[Department Name]" and Operating Room (**Delete if not observing in OR**) to further my educational goals, I hereby release and forever discharge Augusta University and Wellstar MCG Health (formerly AU Medical Center, Children's Hospital of Georgia and formerly AU Medical Associates and its officers, agents, and employees) from all claims, demands, rights and causes of action of whatever kind or nature arising from and by reason of any and all known and unknown, foreseen and unforeseen bodily and personal injuries, death, or damage to property arising out of my observation activities, including but not limited to, those specific risks enumerated above.

I have read this document carefully and I voluntarily choose to participate in the activities described herein. I hereby certify that I am at least 15 years of age, I am legally competent, and I am signing this document with full knowledge of its significance.

Observer's Signature

Date

Observer's Parent or Guardian's signature
(if under 18 years of age)

Administrative Assistant or Coordinator
"[Department Name]"

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OBSERVERSHIP Supervision Agreement for Observerships FORM B

I, "[Supervisor's Name]", the undersigned, agree to be responsible for supervising "[Observer's Name]", while he/she observes the activities of the Department of "[Department Name]" and Operating Room (**Delete if notobserving in OR**) at Augusta University and Wellstar MCG Health during the period of_____.

I acknowledge that I have told "[Observer's Name]" that he/she is to be under my supervision and that he/she is not to be present in any patient care area without supervision by the undersigned. I agree to ensure that "[Observer's Name]" shall engage in observation activities only and shall not participate in any patient care activities at Augusta University and Wellstar MCG Health during "[Dates of Observership]" **to include touching of patients, writing on the medical record, and advising other care providers or patients.**

Supervisor
(Replicate signature line if there are multiple supervisors)

Date

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OBSERVERSHIP

Confidentiality Statement

FORM C

Augusta University and Wellstar MCG Health (formerly AU Medical Center, Children’s Hospital of Georgia and formerly AU Medical Associates) maintain strict confidentiality and security of paper and electronic records in compliance with the Family Educational Rights and Privacy Act of 1974 (FERPA), the Health Insurance Portability and Accountability Act (HIPAA) and the Georgia Personal Identity Protection Act (GPIPA) in addition to other federal and state laws. These laws pertain to the confidentiality and security of all records that contain directly identifiable information that could reveal private information concerning our students, our customers and patients, our research participants and our employees and volunteers.

Our employees, students, volunteers and authorized others may access such private information to the extent necessary to perform their duties within our university and our health system. As an individual with access to private information at any of our institutions, you are required to protect against unauthorized access and disclosure, to ensure the privacy and security of records and to report any credible threats or known violations related to this private information. You must be very careful not to release this information to any individuals, including but not limited to unauthorized university or health system employees who do not have a **work or business-related need to know**. If in doubt, you should act to preserve the confidentiality of such private information until you have verified the work or business-related need for access through your supervisor or his/her designee, one of our legal offices or the Enterprise Privacy Officer.

Wellstar MCG Health, Augusta University and Children’s Hospital of Georgia define **unauthorized** access or disclosure as:

- Access to student, patient, research participant, employee or volunteer information not necessary to carry out your job responsibilities. This includes access to the private records of your family, friends and acquaintances that is not for a legitimate business use.
- Disclosure of student, patient, research participant, employee or volunteer records to unauthorized internal or external recipients.
- Disclosure of additional or excessive student, patient, research participant, employee or volunteer information to an unauthorized individual/agency than is essential to the stated purpose of an approved request.

Information may not be used, disclosed, copied, sold, loaned, reviewed, altered or destroyed except as properly authorized by the appropriate university or health system official within the scope of applicable federal or state laws, including record retention schedules and corresponding policies. No university or health system workforce member or other individuals are permitted to realize any personal gain as a result of disclosing or using confidential information. This obligation of nondisclosure or unauthorized use continues indefinitely, even after your relationship with the university and health system ends.

As an employee, student or volunteer of Wellstar MCG Health, Augusta University and Children’s Hospital of Georgia, you must abide by our rules, regulations, policies and procedures, as well as federal and state laws applicable to your position at the university or health system. Your failure to comply with any applicable law or procedure may result in the revocation of your access to confidential information; disciplinary action, including termination of employment or student status; criminal and/or civil penalties, depending upon the nature and severity of the breach of confidentiality.

I have read the above Confidentiality Statement and understand my obligation as an employee, student or volunteer to ensure the confidentiality of information.

Printed Name: _____

Circle One: AU / AUMC / AUMA

Circle One: Employee / Student / Volunteer / Other

Signature: _____

Date: _____



OPERATING ROOM OBSERVERSHIP ORIENTATION

I have viewed the OR Observer Orientation video accessed online at

<https://echo360.org/media/0d6c4682-e154-416b-be44-7a423af324f6/public>

I understand my role as an observer in the Operating Room.

I understand that I get scrubs from the Department I am doing the observership through ----NOT from the Operating Room.

I certify that I am at least 17 years of age.

I will not participate in patient care and that I will **NOT** scrub into surgeries and/or procedures.

I understand that failure to abide by all relevant AU and Wellstar MCG Health policies, procedures, rules, regulations, guidelines and requirements will result in my observership being terminated.

Printed name: _____

Signature: _____

Date: _____