Attachment A

DUKE UNIVERSITY HEALTH SYSTEM
Visiting Observer Agreement
(Non-Physicians and Non-Physicians in Training)

I, ____, will be participating as a visiting
Name
Observer, under the direct supervision of ______________________(Sponsor) and sponsored

by the department of ____ beginning
Department Name
_____________________, 20___ and concluding ___________________, 20___.
Day/month *Day/month*

Purpose of the Activity:

Please provide 3 measurable goals and 3 objectives for meeting those goals.

____

____

____

As a visiting observer, I understand that I do not have any clinical privileges and will not engage in any type of clinical activity while I am at ______________________________ (name of hospital/clinic). I also understand that, in the event that I am requested to participate in any clinical activity, I must decline. I understand that I must be escorted by my Sponsor/Sponsor designee at all times.

I will be participating in certain learning activities at ________________________________ (name of hospital/clinic). In conjunction with these activities, I may come in contact with patient confidential information through my Sponsor. In consideration for my being allowed to participate in this activity, I hereby acknowledge and agree that I will in no way copy or preserve by paper writing, electronic, picture, or by any other means any patient specific information nor any patient identifying information.

Further I acknowledge and agree that I have signed the Duke Confidentiality Agreement and will not communicate nor discuss any patient specific information with anyone except those involved with learning activities who are also workforce members of

the Duke Health Enterprise. I promise and agree to keep confidential all patient information and to respect the privacy of all patients.

In the event of an emergency, I will follow my Sponsor's instructions.

I make these promises and representations freely and voluntarily, and I understand that others are acting in reliance on them.

____

Signature of Visiting Observer *Date*

Print Name ____

Permanent Address ____

Telephone Number (home)____________________(mobile)______________________________

As the Sponsor of this Visiting Observer, I acknowledge that I am responsible to assure that the activity remains in compliance with all established policies and procedures and that the privacy and confidentiality of our patients is respected.

I also acknowledge that I am responsible for escorting the Visiting Observer continuously during the observation experience.

As part of this Observation, I attest that the Visiting Observer may be in the following areas:

____

____

____

Name of Division Chief or Department Manager *Telephone #* *eMail Address*

____

Signature of Division Chief or Department Manager *Date*

****
If Visiting Observer will be in multiple departments, more than one Administrator/Clinical Director signature may be necessary.

____

Name of DUHS/PDC Administrator or Clinical Director (Print)

____

Signature of DUHS/PDC Administrator or Clinical Director *Date*

To be kept on file in the Sponsor's office.