London Health Sciences Centre

OBSERVER REQUEST FORM

Full Name of Observer: (print) _____(Attach a current C.V or resume).

Category of Observer:

[ ] Physician [ ] Dentist [ ] Midwife [ ] Other *(please specify)* _____

Purpose of Visit:
Explain what learning outcomes you expect to accomplish during your Observership

_____

_____

Start and End Dates of Observership:
Please indicate your anticipated start and end date (yyyy/mm/dd).

Start: _____ End: _____

Sponsor Information:
Your Observership must be sponsored by a staff member or physician at the organization (a signature is required on page 2 of this document).

Sponsor's Name: _____ Ext: _____

Sponsor's Title: _____

Department(s)/Program(s) of Observership:
List all programs and departments, including specific divisions/areas you wish to observe, if known:

_____

_____

Observer Location(s):
Please check all hospitals that apply to your request for Observership.

London Health Sciences Centre:
[ ] University Hospital [ ] Victoria Hospital [ ] South Street Hospital

Please continue to Read the Agreement & Acknowledgement of Role & Accountabilities.

1. The Observer ***will not***, under any circumstances, be involved in any form of direct patient care. Patient care involves, but is not **limited to**:
   - taking a medical history,
   - conducting physical examinations,
   - diagnosing or treating patient's condition,
   - ordering, preparing or administering drugs,

- documenting on patients' health records, either in electronic or hard copy format,
- having independent access to heath records, either in electronic or hard copy format,
- performing or assisting in surgical procedures, or diagnostic patient interventions
- obtaining consent,
- interacting directly with patient/SDM.
- providing health care advice.

2. All Observers must comply with London Health Sciences Centre Observer Policy for Medical and Non-Medical Observers; and any other relevant development policies and procedures as discussed with the sponsor.

3. All Observers are required to maintain patient confidentiality regarding all cases observed. **(You must read and sign the LHSC Observer Privacy & Confidentiality Agreement included in this package – Appendix B).**

4. Your sponsor must obtain a patient's verbal consent for your presence prior to any patient contact. A patient's right of refusal is to be respected at all times.

5. You must complete the Self-Screening Health Evaluation and return it with your documentation package and you must acknowledge that you have completed and agree to comply with the information presented on the form. (**Appendix C**)

6. You must complete the Infection Prevention and Control Core Competency Training and return it with your documentation package and you must acknowledge that you have completed and agree to comply with the information on the form. (**Appendix D)**

7. You must attach a current version of your C.V (or resume). A short version is acceptable.

Observer:

- ☐ I have read and fully understand the information provided in this documentation package.
- ☐ I am aware of and agree to comply with the aforementioned roles and accountabilities.
- ☐ I have completed and confirm my compliance with the Self-Screening Health Evaluation Form.
- ☐ I have completed and confirm my compliance with the Infection Prevention and Control Competency Training.
- ☐ I have attached a current copy of my C.V (or resume)

Signature: _____ Date: _____

Sponsor:

I agree that it is safe and appropriate for the above individual to assume an Observer role and acknowledge the aforementioned roles and accountabilities.

Printed name _____

Signature: _____ Date: _____

Department Chief/Program Director/Professional Practice Leader:

I support the above Observership and acknowledge the aforementioned roles and accountabilities.

Printed name _____

Signature: _____ Date: _____