Medical Staff Services
1414 Kuhl Ave., MP38
Orlando, FL 32806
407.841.5139 FAX: 407.841.5255

Dear Applicant:

In response to your request for an Observership Agreement Application at Orlando Health, attached are the following:

1. Observership Agreement Application – **Applicant must complete, sign and date application. Applicant is also responsible for obtaining his/her Sponsoring Physician's signature** ***(dates of Observership must allow for the processing of this agreement)***, and
2. Consumer Report Agreement – **Applicant must complete, sign and date.**

The request for an Observership will be for a period of **sixty (60) days**. The observership application fee is $100.00 (check made payable to Orlando Health or Credit Card payment with a Visa or MasterCard). ***Please be advised processing of your application will begin when the completed application, supporting documentation required and $100 application fee have been received in Medical Staff Services. If all supporting documentation required and fee are not received with the completed application, the processing of your application will be delayed. The Observership application process will take approximately ten (10) working days (please note that out of country applicants take longer due to the Criminal Background Check (CBC) from the receipt of the request; therefore, please state an appropriate start date that will take processing time into consideration.***

PPD skin test results within 1 year of the receipt date of your application must be submitted as part of the Observership application process; therefore, if you have not had a PPD skin test done recently, please have one done and submit the results to Medical Staff Services.

All observers are asked to receive a flu vaccine during peak flu season (October 1 – April 30). Those who do not receive the vaccine are required to wear a surgical mask while within six feet of patients. Please provide documentation that you have received a flu shot. If you decline to do so, please provide a statement in writing.

Upon completion and appropriate approval from the Sponsoring Physician's Department Chairman and the Chief of Staff, a copy of the completed agreement and the approval letter will be sent to the Sponsoring Physician and Applicant.

Should you have any questions, please do not hesitate to contact me for assistance.

You can submit the application via e-mail to mss@orlandohealth.com or via fax to 407-841-5255.

Sincerely,

Orlando Health
Medical Staff Services

Revised: 02/03, 03/05, 05/06, 12/07; 02/08; 03/08;0 9/09, 07/10, 01/14

ORLANDO HEALTH
When it matters most.

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OBSERVERSHIP AGREEMENT APPLICATION

☐ **Non-Applicant Physician** ☐ **Medical Student**
☐ **Non-Applicant Allied Health Practitioner** ☐ **College Student (must be at least 18 years old)**

Applicant Name ____
(Last) (First) (M) (Email address)

Home Phone #:__________________ **Cell Phone #:**________________ **Fax #:** ____________________________

Address ____
(Street Number/Name) (City) (State) (Zip)

Social Security #: _______ - _____ - _______ **DOB** ___________ **Gender M**_____ **F**_____

College/Med School: ____

Emergency Contact: ____
(Name) (Phone) (Relationship)

Reason for Observership: ____

Requested Dates: ___________________________ **to** ___________________________ ***(Maximum of 60 days Only)***

Sponsoring Physician: _______________________________________**Specialty:** _____________________________

The applicant whose signature appears below understands and agrees to the following:

I. I fully understand that Observership means “No hands on” patient contact, and I must be in the presence of my sponsoring physician at all times.
II. I will conduct myself in an ethical, professional manner at all times during my Observership at Orlando Health (OH).
III. I will comply with the OH dress code and adhere to the policies and procedures of OH.
IV. I understand that I am to report to and am directly responsible to the Sponsoring Physician indicated above.
V. I understand that OH has the right to remove me from its facilities and to terminate the Observership if my behavior is unsatisfactory, disruptive, or otherwise detrimental to OH, and I acknowledge that I am not entitled to any appeal or other procedural rights in connection therewith.
VI. I acknowledge and understand that while I am observing in a clinical setting at OH, I am subject to the possibility of contracting diseases or bodily injury as a result of activities in the facility. I further understand that OH does not insure observers against these possibilities, and I expressly hereby assume this risk and acknowledge OH is not responsible for any such loss. I may be offered Emergency Room service at my own expense.
VII. In consideration of the status being granted to me by OH for Observership, I hereby assume all risk of personal injury or death and property damage. I agree to release OH, its officers, employees, agents, and servants from any liability.
VIII. In no event shall OH be liable to provide indemnity for any acts or omissions for any physician or other health care personnel or provider who is not an employee(s) of OH.
IX. I understand and agree that when I am observing at OH, I must keep patient and hospital information confidential. I understand that this information includes medical records, computer records and files, information about suppliers and agreements with hospital, computer passwords, personnel files, and any other OH related material that has been identified as confidential. I also understand that if I intentionally share confidential information, OH may seek legal remedies against me.
X. I will obtain an identification badge from the badge room which will be time limited and which must be returned to OH immediately upon the conclusion or termination of the Observership.
XI. I fully understand that a Consumer Report will be obtained, which may include a criminal background check.
XII. I am at least eighteen (18) years of age.
XIII. **I understand and agree to pay the $100 non-refundable application fee for Observership application processing.**

Observer Applicant’s Signature _____________________________________ **Date** ___________________

Sponsoring Physician’s Signature _____________________________________ **Date** ___________________

Medical Staff Services Use Only

☐ **Approved /** ☐ **Not Approved:** _____________________________________ ______________________
Date
Chairman, Department of_____________________________________

☐ **Approved /** ☐ **Not Approved:** _____________________________________ ______________________
Chief of Staff **Date**

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NOTICE THAT A CONSUMER REPORT MAY BE OBTAINED
AND
AUTHORIZATION TO OBTAIN/RELEASE CONSUMER REPORT

Notice That a Consumer Report May Be Obtained

This Notice is to inform you that Orlando Health may obtain a consumer report from a consumer reporting agency for use in connection with your Observership Agreement Application. A consumer report may contain information bearing on your character, general reputation, personal characteristics, and/or mode of living. It may include a criminal background check.

Please read the "Authorization to Obtain/Release Consumer Report" below. This authorizes Orlando Health to obtain a consumer report concerning you and authorizes consumer reporting agencies to provide a consumer report to Orlando Health.

Your Observership Agreement Application to Orlando Health will not be considered complete and will not be processed without this signed authorization.

Authorization to Obtain/Release Consumer Report

I have been notified that Orlando Health will obtain a consumer report on me for use in connection with my application for observership.

I hereby authorize Orlando Health to obtain a consumer report on me.

I hereby authorize and instruct any consumer reporting agency to furnish Orlando Health a consumer report concerning me upon request. I agree that a photocopy of this authorization may be accepted with the same authority as the original.

Signature ___________________________________

Print Name ___________________________________

Date ___________________________________

The following is requested for identification purposes:

Social Security Number _________________________

Date of Birth _________________________

Revised: 02/03, 03/05, 05/06, 12/07; 02/08; 03/08;0 9/09, 07/10, 01/14