

# Sparrow Hospital and Health System Clinical Observer/Educational Agreement\*

Observer's Name	Sponsoring Program	Rotation/Service Requested	From:	To:
Current Education Class/Program	Contact Person for current Class/Program	Phone Number		
E-Mail Address	Fax Number			

As the applicant for this Clinical Observer/Educational Experience, I understand the following policies and agree to abide by them:

1. I recognize that as an unlicensed person I can only function as an observer.
2. I may participate in educational rounds, conferences and other Medical Education activities as directed by the responsible faculty.
3. I will maintain confidentiality and have signed the attached Confidentiality Agreement.
4. I may have patient contact within the following limits:
  - I will not do any physical examination of a patient;
  - I may verbally interact with a patient only with his/her approval and in the presence of a Senior Resident or Attending Physician who will be responsible for ensuring appropriate, professional and accurate communications;
5. I will not write in the medical record, although I may be given "mock" documentation exercises to practice documentation and have my skills assessed outside of the official medical record. I understand that I must receive instruction on aseptic technique and that during surgery or any procedure, I may not be near the surgical field or table, but may observe the activity with other members of the team. I will follow the directions of the physician or supervising nurse.
6. I have obtained sponsorship by a Sparrow Hospital, Affiliated Residency Program or Medical Staff Member as indicated by the Residency Program Director's Signature below.

As the **applicant** I have read, understand and agree to the above conditions of participation in this Clinical Educational Experience.

\_\_\_\_\_ / / \_\_\_\_\_  
Applicant Signature Date

Local telephone/pager number where I can be reached during this experience: \_\_\_\_\_

As the **Residency Director** of the Program **or Medical Staff Member** sponsoring Clinical Observer/Educational Experience, I verify:

- the individual has met the criteria to participate in this Clinical Observer/Educational Experience
- the program has the process in place to monitor the individual's performance
- this observer is introduced to patients appropriately and there are no objections
- the program has established supervision consistent with this policy.

\_\_\_\_\_ / / \_\_\_\_\_      \_\_\_\_\_ / / \_\_\_\_\_  
Authorized Signature (Residency Director or Medical Staff Member)      Director of Medical Education  
Date      Date

**\*Note: To be used when the "Observer" is with a physician and is not necessary when general approval is given for an event such as "Bring your child to work day".**



1215 East Michigan Avenue  
PO Box 30480  
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**Acknowledgement of  
Sparrow Health System  
Confidentiality and Security  
Obligations and/or Conditions**

As an observer of a Sparrow Health System entity, you may have access to confidential information including patient, financial or business information obtained through your association with Sparrow Health System. The purpose of this Agreement is to help you understand your personal obligation regarding confidential information.

Confidential information includes any information about a person's past, present, or future physical or mental health; the health care services provided to the individual or payment information related to such services, that identifies the individual or provides enough information that there is a reasonable basis to believe the information could be used to identify the individual.

Confidential information is valuable and sensitive and is protected by law and by strict Sparrow Health System policies. State law and the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), require protection of confidential health information. Inappropriate disclosure of confidential health information regarding patients may result in the imposition of fines up to \$250,000 and ten years imprisonment per incident.

Accordingly, by signing this acknowledgement and, having as a condition of and in consideration of access to confidential information whether in oral, paper, electronic, or any other form, I acknowledge the following obligations and conditions:

I, \_\_\_\_\_ Acknowledge that any and all information related to: (1) Sparrow Health Services (Sparrow Hospital) treatment of its patients; and (2) the conduct by Sparrow Hospital of providing health care, is strictly confidential and constitutes the exclusive property of Sparrow Hospital and that the use or exposure of such matters, will be contrary to the best interest of Sparrow Hospital and will cause harm and damage to Sparrow Hospital and its medical practice. In furtherance and on account thereof, I covenant and agree not to use or disclose to others, either during the term of my clinical program at Sparrow Hospital or after termination of my clinical program for any reason, except as expressly consented to by Sparrow Hospital, which shall include, without limitation, patient lists, patient files, patient records, personnel files, fee schedules or any other such information.

Without limiting the generality of the foregoing Paragraph A, I further agree that during the term of my clinical program and after termination of my clinical program, I shall not use, disclose, take or retain, without prior written authorization of Sparrow Hospital, any papers, medical data, patient lists, fee schedules, files or other documents or copies of any of the same pertaining to Sparrow Hospital's provisions of health services, Sparrow Hospital's business, financial condition or other activities, all of which I acknowledge are confidential and constitutes the exclusive property of Sparrow Hospital.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date