WOMEN'S COLLEGE HOSPITAL
Health care for women | REVOLUTIONIZED

medical affairs

MEDICAL OBSERVERSHIP APPLICATION

Please allow a minimum of 10 business days for approval process

Attach a copy of photo identification to this application and any other required documentation as outlined below

Name of observer: _____ Male [ ] Female [ ]
First name Last name

Observation start date: _____ End date: _____
Day Month Year Day Month Year

Name of Staff Supervising Physician: _____ Department: _____

Are you requesting an observership in the operating room? [ ] Yes [ ] No

Note: Before the observer enters the OR the patient must be prepped and fully draped.

Profession [ ] Ontario-licensed Physician [ ] Visiting Physician from: _____

Specialty: _____ Attach proof that you hold a valid medical license.

[ ] Medical Student registered with (attach proof) _____ Medical School/University

[ ] Student – Other (Identify institution and attach proof) _____

[ ] Pharmaceutical representative (Identity company and attach proof) _____

[ ] Other _____

Describe the purpose of the observership and identify specific information you wish to obtain: _____

_____

_____

Address: _____

Phone number: _____ E:mail: _____
Daytime / Cell

Confidentiality and the protection of personal health information:

I agree not to engage in patient care or to have patient contact of any kind during this observership. I also agree not to review any patient related documents such as health records, test results, etc., nor take any videos or photographs whatsoever. I also agree not to discuss any information concerning patients, hospital personnel or other privileged hospital information during or after the observership. I am aware that the observership is for the purpose of education only and that I am not entitled to hospital resources such as access to the hospital's computer network and its various clinical databases. Attach copy of signed Confidentiality Agreement.

_____ _____
Observer's Signature Date

Staff Supervising Physician: I agree to provide appropriate supervision and to ensure that all activities engaged in are for educational purposes only.

_____ _____
Signature of Staff Supervising Physician Date

Approved by: _____ _____
Department Chief Date

Approved by: _____ _____
Dr. S. Laredo, Chief of Staff Date

:fj March 19, 2014

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Women's College Hospital Confidentiality Agreement

I acknowledge that I understand the WCH policies and procedures on privacy, confidentiality and security (together "the Policies").

I understand and agree that:

- I shall comply with the Policies;
- it is a condition of my employment, privileges and/or other affiliation with WCH that I comply with the Policies;
- my failure to comply may result in the termination of my employment, privileges and/or other affiliation with WCH and may also result in legal action being taken against me by WCH and others; and
- more specifically regarding access codes and devices, I shall keep my computer access codes (for example, passwords) confidential and secure and I shall protect physical access devices (for example, keys and badges) and the confidentiality of any information being accessed. I understand that I have legal responsibility for my access code(s) and device(s) and that I am accountable for all work and/or activity performed under these codes. If I have reason to believe that my access codes or devices have been compromised or stolen, I shall immediately contact the WCH Help Desk.

I agree that I shall not:

- disclose any confidential business and/or other information including but not limited to financial, intellectual property, personal, and/or personal health information (together "Confidential Information") that I have knowledge of or am in possession of, through or because of my employment or affiliation with WCH, other than when it is necessary for me to do so in order to perform my job responsibilities and only in compliance with the Policies;
- under any circumstances communicate Confidential Information either within or outside WCH except to other persons who are authorized by WCH to receive such information;
- alter, destroy, copy, disclose or interfere with Confidential Information, except with authorization and in accordance with the Policies; and/or
- lend my access codes and/or devices to anyone, nor shall I attempt to use those of others.

Date: _____/_____/_____ Signature: _____
Year Month Day

Date: _____/_____/_____ Witness: _____
Year Month Day

As of December 3, 2013

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