

Providence Observational Rotations All Learner Types

We at Providence Health & Services – Oregon Region are excited to provide an observer experience to help enhance and guide you in your career path decisions. For your protection and the protection of our patients at Providence Health & Services, observers who are at our facilities **more than 8** hours must complete the following forms prior to their experience.

The following documentation is necessary to have you on our campuses in our patient care areas. This is necessary for all non-patient specific visitors as well.

- Background check, which includes social security number trace, OIG sanctions list and GSA/EPLS, criminal history and sex offender registry.
- A 10-panel drug screen, which includes Amphetamines (including methamphetamines), Barbiturates, Benzodiazepines, Cocaine, Marijuana, Methadone, Opiates, Phencyclidine.
- Health Screen verification, which includes a TB exposure screening, full COVID-19 vaccination, annual influenza vaccination, Measles, Mumps, Rubella (MMR), Varicella immunizations, Hepatitis B vaccination and Tetanus/ Diphtheria/ Pertussis (Tdap) vaccine.
- Observational Rotation Application request – complete pages 2 - 6
 - Applicant Behavior, Conduct and Performance Expectations
 - Providence Non-Employee Behavioral Standards and Privacy Attestation
 - Providence Non-Employee Confidentiality and Non-Disclosure Attestation
 - Release of Liability Form

When you have completed the packet, *please forward it via e-mail as one pdf attachment to the Staff Member through whom you coordinated your experience 4 weeks* prior to the beginning of your Observational Rotation. This will help to avoid delays and allow you to start your experience on time.

The Staff Member will then complete page 7 and coordinate clearance through our Student Affiliation team. **You will receive an approval notification from their office. Please note that you cannot start your Observational Rotation unless you receive this notification.**



Observational Rotation Application Request

Print or type all information. *A detailed explanation of requirements is included in the Compliance Packet available online. Please complete all forms and submit 4 weeks prior to the beginning of the rotation. Accuracy, timeliness, and completeness are the keys to avoiding delays in completing this process.*

Name: (Last) _____ (First) _____ (MI) ____ Suffix: _____

Gender: M ____ F ____ Other _____ Date of Birth _____ SSN*: _____
(mm/dd/yyyy)

Home Address: _____ City/State/Zip: _____

Email Address: _____ Telephone: _____

U.S. Citizenship: Yes ____ No ____ If no, indicate current visa status _____

Dates of Observational Experience Rotation: _____ to _____

Supervising Medical Staff Member: _____

Providence Facilities: Check all that apply to this observation only

- | | |
|--|---|
| <input type="checkbox"/> Providence Hood River Memorial Hospital | <input type="checkbox"/> Providence Portland Medical Center |
| <input type="checkbox"/> Providence Medford Medical Center | <input type="checkbox"/> Providence St. Vincent Medical Center |
| <input type="checkbox"/> Providence Milwaukie Hospital | <input type="checkbox"/> Providence Willamette Falls Medical Center |
| <input type="checkbox"/> Providence Newberg Medical Center | <input type="checkbox"/> Providence Seaside Hospital |
| <input type="checkbox"/> Providence Cancer Center | <input type="checkbox"/> Providence Outpatient Clinic _____ |

**Social Security Number (SSN) is required.*

Applicant Behavior, Conduct and Performance Expectations

I shall clean my hands with alcohol hand rub or soap and water before and after every patient specific observation to protect patients from hospital acquired infections. I will work cooperatively, collaboratively and constructively with other health care member and with the health system and hospital employees to avoid disruption of the patient care and operation of the hospital. This included but is not limited to the following:

Professional Expectations:

Treat all patients, families, Members and health system employees with respect, courtesy, and dignity, in language and nonverbal behavior.

Maintain confidentiality in all health care matters.

Assure that all interactions with health system employees are free of hostility; verbal mental and/or physician harassment, intimidation, sexually suggestive or explicit behavior, retribution implied or explicit on campus or in the community, behavior that is profane, vulgar, or demeaning toward others, violations of reasonable personal space.

Assure that conflict, described in objective behavioral terms, is resolved in a professional, constructive manner, through established mechanisms, and in a confidential manner when performance or competence issues arise, refraining from derogatory or demeaning comments to others.

Conduct care in a way consistent with the faith tradition of Providence Health & Services, as expressed in such places as the Ethical and Religious Directives for Catholic Health Services, and to make use of the ethical resources available, such as the ethics consultation team at the specific facility or the Providence Center for Health Care Ethics when there are questions regarding these directives or general ethical principles.

Applicant's Printed Full Name

Date (mm/dd/yyyy)

Applicant's Signature

Providence Non-Employee Behavioral Standards And Privacy Attestation

Behavior

- All Providence observer opportunities are a privilege. It is expected that observers conduct him or herself in the behavior and decorum expected of a professional.
- Observers are expected to refrain from participating in patient care. Observers are to demonstrate active listening skills, eye contact, a positive attitude and positive non-verbal communications. Observers are to eagerly engage in dialogue with staff and to be accepting and encouraging of other team members.
- Any Providence employee may remove the observer from the clinical environment if it is suspected that the Observer is under the influence of drugs or alcohol, the presence of the observer is assessed as unsafe for the patient, or if the observer is disruptive to the clinical care of the patient.

Respectful Treatment

- Providence facilities are places of business and observers are expected to exhibit a professional demeanor and appearance at all times.
- Observers will adhere to Providence facility dress code and policies and wear appropriate ID badge(s) any time they are at the facility for their observational experience.
- All Providence staff, vendors, contract personnel, volunteers, school personnel, students, patients, their families and visitors shall be treated in a respectful, dignified manner at all times. Language, non-verbal behavior, gestures, attitudes and activities shall reflect this respect and dignity of the individual at all times.

Drugs and illegal substances

- Regardless of the legality of a drug, Providence is a drug free environment observers are expected to abstain from the use of drugs while at any Providence facility.

Photography, Cell Phones/electronic devices & Social Media

- Cell phones are not allowed in any clinical procedural area (OR, endoscopy, catheter lab, etcetera). Please leave them at home, in your car, or in a locker in the scrub change area.

Photography of patient, body part, staff, or clinical environment is absolutely prohibited and grounds for removal from any Providence facility indefinitely and may result in legal action by the patient or Providence.

- The observer may not share any information about patients, staff, clinical environment or learning experience via any social media venue. Doing so is grounds for removal from Providence indefinitely and may result in legal action by the patient or Providence.
- No Observer is to use an iPod or other music and/or video device, cell phones, laptops or other computer devices, do homework or otherwise veer from the learning experience.

Applicant's Printed Full Name

Date (mm/dd/yyyy)

Applicant's Signature

Providence Non-Employee Confidentiality and Non-Disclosure Attestation

- I understand that in the course of observing at Providence Health System – Oregon (PHS-OR) campuses, I may be exposed to information not generally available or known to the public. I agree that such information is confidential information that belongs to PHS-OR. Confidential information includes but is not limited to patient, customer, member, provider, group, physician, employee, financial and proprietary information, whether oral or recorded in any form or medium. I agree that information developed by me, alone or with others, may also be considered confidential information belonging to PHS – OR.
- I will hold confidential information in strict confidence and will not disclose or use it except as authorized by PHS-OR.
- I understand that this Confidentiality and Nondisclosure Statement does not limit my right to use my own general knowledge and experience, whether or not gained while contracting with PHS-OR, or my right to use information if this is or becomes generally known to the public through no fault of my own.
- I will not access confidential information for which I have no legitimate need to know.
- I understand my responsibility to become familiar with and abide by applicable PHS-OR policies and protocols regarding the confidentiality and security of confidential information.
- I understand that PHS-OR electronic communication technologies are intended for benefit of PHS-OR, however limited personal use is permitted. Personal use is defined as incidental and occasional use of electronic communications technologies for personal activities that should normally be conducted during personal time and is not in conflict with PHS-OR business requirements. Internet usage is monitored and audited on a regular basis by PHS-OR management. PHS-OR management also reserves the right to monitor e-mail and telephone usage.
- I understand that if I breach the terms of this confidentiality and nondisclosure statement or applicable PHS-OR confidentiality, privacy and/or security policies, PHS-OR may terminate my association with PHS-OR, including any written Agreements with PHS-OR. Further, PHS-OR will be entitled to all remedies it may have under written Agreement or at law, as well as to seek and obtain injunctive and other equitable relief.
- I have reviewed, understand, and agree to comply with the student behavior standards.

Applicant's Printed Full Name

Date (mm/dd/yyyy)

Applicant's Signature

**RELEASE OF LIABILITY FORM FOR JOB SHADOW AND/OR UNPAID
INTERNSHIP**

Providence Health & Services Oregon onsite career educational activities such as job shadowing and internships carries the potential for certain risks some of which may not be reasonably foreseeable.

I acknowledge that these risks could cause me, or others around me, harm, including, but not limited to, bodily injury, damage to property, emotional distress, or death.

I am a willing participant in Providence Health & Services Oregon onsite career educational activities.

I acknowledge that for a job shadow experience I am only to observe and that I am not to provide patient care. I will follow all Providence Health & Services confidentiality policies and protocols and I read the HIPAA training provided by Providence and have signed the Providence Non-Employee Confidentiality Form. I agree that participating in onsite educational experiences are for my informational purposes and do not constitute employment or an offer of employment.

By signing this agreement, I agree to release, indemnify, and hold harmless Providence Health & Services-Oregon, as well as all its employees, agents, representatives, successors, etc. from all losses, claims, theft, demands, liabilities, causes of action, or expenses, known or unknown, arising out of my participation in onsite career educational activities.

Applicant's Printed Full Name

Date (mm/dd/yyyy)

Applicant's Signature

Medical Staff Member Agreement

- I attest that I am aware of and have read the Medical Staff Bylaws pertaining to Medical Observers.
- I agree to accompany the observer at all times while in patient care or other restricted areas of the Providence Health & Services campuses.
- I agree to make patients aware of and gain verbal consent to having the observer present during all aspects of the patient encounter.
- I agree to ensure the observer does not access medical records or participate in direct patient care performing activities such as interviewing patients, examining patients, providing medical advice or assisting in procedures.
- I agree to involve the observer in discussions of patient interactions and clinic findings as appropriate.
- I agree to involve the observer in educational events on the Providence Health & Services campuses during the observational experience as applicable and appropriate.
- I agree to ensure that the observer wears a Providence issued badge identifying them as an observer.

Supervising PHSOR Medical Staff Signature

Supervising PHSOR Printed Name

Date (mm/dd/yyyy)

I attest that I have agreed to allow observers in our department and the Medical Staff Member, whose signature appears above and has agreed to accept an observer onto service, is in good standing with the Medical Staff Office and has approval to supervise the observer while on Providence Health & Services campuses.

Providence Department Chair Signature

Providence Dept. Chair Printed Name

Date (mm/dd/yyyy)

Student Health Requirements

In supporting and creating healthier caregiver communities and to promote our vision of Health for a Better World, our student/agency/vendor/contractor partners must have the following health requirements assessed before starting their regular work assignment /rotation/shadow/visitation in any Providence St. Joseph Health facility or affiliate building where patients are treated, or caregivers perform work.

Please provide documentation to your administrator to keep on file:

Health Requirement	Check
Annual Health Screen -CA HCC Caregivers Only Indicate free of infectious disease, able to work with or without accommodation (specify any accommodations needed) and signed by MD, DO, NP or PA	
Tuberculosis Testing -- Tuberculosis testing; IGRA or Q-Gold blood test or two-step tuberculin skin test current within the last 12 months, and annual as per ministry requirements. If history of positive, please provide copies of chest x-ray results after positive TB test and medical clearance note from your provider.	
Measles, Mumps, Rubella (MMR) – Documentation of 2 MMR’s at least four weeks apart after the age of one and/or positive laboratory titer. If laboratory titers are negative, one of the below actions must be completed: <ol style="list-style-type: none"> 1. Written vaccination declination 2. Acceptance of vaccine <i>(Rubella vaccination is required in Alaska in acute facilities, skilled nursing facilities, and ambulatory surgery centers)</i>	
Varicella (Chicken pox) – Documentation of 2 doses of varicella at least four weeks apart and/or positive laboratory titer. If laboratory titers are negative, one of the below actions must be completed: <ol style="list-style-type: none"> 1. Written vaccination declination 2. Acceptance of vaccine 	
Hepatitis B (Hep B) - Documentation of Hepatitis B vaccinations (series of 3 Engerix or Recombivax or 2 Heplisav) and positive laboratory titer. If laboratory titers are negative, one of the below actions must be completed: <ol style="list-style-type: none"> 1. Written vaccination declination 2. Acceptance of vaccine <i>(Hep B vaccination is required in Alaska in acute facilities, skilled nursing facilities, and ambulatory surgery centers)</i>	
Tetanus, Diphtheria & Pertussis (Tdap) – Documentation of vaccination/booster or signed declination	
Annual influenza vaccine -- Documentation of vaccination or signed declination, including reason for declining. Must follow masking requirements of setting.	
COVID vaccination- Documentation of updated (most current) COVID-19 vaccine. Students for whom vaccine status is unknown or documentation is not provided, are considered unvaccinated and will be required to comply with local masking policy.	
Respirator Training: Respiratory Protection (PAPR or N95 Fit Mask Testing), if required by setting or functions performed. If prior training is not for device provided by PH&S, PH&S will provide training/testing as appropriate.	

I understand the declination of some vaccines may limit the locations where I am able to work. I hereby attest that I provided my administrator all the necessary medical documentation as outlined above in order to meet the health requirements of Providence St Joseph Health. I have done this to protect myself, our patients, colleagues, and the community.

Signature

Printed Name

Date

Administrator Signature

Printed Name

Date

Ideas on where to obtain your childhood and adult immunization immunity records:

- Previous health care employers or any schools you have attended
- Your family Physician or the Health Department where you grew up, which may take a couple weeks.
- Call your state **Immunization Registry Help Desk** as they may have record of your immunizations and can send them to you.

Ideas in where to receive vaccinations:

- Your Primary Care Provider or other walk-in clinics
- Local and national pharmacy stores/chains, some located in grocery stores chains.
- Family Practice Residency programs
- Low income or sliding scale clinics
- Local Health Department