Providence Observational Rotations
All Learner Types

We at Providence Health & Services – Oregon Region are excited to provide an observer experience to enhance and guide you in your career path decisions. For your protection and the protection of our patients, observers who are at our facilities **more than 8** hours cumulatively must follow the steps below 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. Please allow 4 – 6 weeks (8 weeks for international requests) for processing.

Step 1: Compile the following documentation:

- Background check, which includes Social Security Number trace, OIG sanctions list and GSA/EPLS, criminal history and Sex offender registry. For international requests, this should be a global background check.
- 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, annual influenza vaccination, Measles, Mumps, Rubella (MMR), Varicella immunizations, Hepatitis B vaccination and Tetanus/ Diphtheria/ Pertussis (Tdap) vaccine.

If you need assistance in getting a background check and/or drug screen completed, please contact ORRegHRStudentAffiliation@providence.org.

Step 2: Complete pages 2 – 6 of this document, Observational Rotation Application Request

- 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

Step 3: When you have completed the packet, ***please forward it via e-mail, preferably as one pdf attachment, to the Staff Member through whom you coordinated your experience 4 – 6 weeks (8 weeks for international requests)*** prior to the beginning of your Observational Rotation. This will help avoid delays and allow you to start your experience on time.

Step 4: The Staff Member will then complete page 7 and coordinate clearance through our HR 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. *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 <u>this observation only</u>

____ Providence Hood River Memorial Hospital
____ Providence Medford Medical Center
____ Providence Milwaukie Hospital
____ Providence Newberg Medical Center
____ Providence Cancer Center
____ Providence Portland Medical Center
____ Providence St. Vincent Medical Center
____ Providence Willamette Falls Medical Center
____ Providence Seaside Hospital
____ Providence Outpatient Clinic _____

**Social Security Number (SSN)* <u>is required</u>. You may opt to contact the staff member to relay your personal identification information directly rather than email it.

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, etc.). 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 recoded 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)