# Shadowing/Observership Application

Drexel University Physicians and its clinical practice sites are a teaching institution and as such, allows for shadowing experiences in accordance with our policies. This experience is observational in nature and patient contact is strictly prohibited. Each patient will be asked for their permission to be observed and only those granting permission will be part of the shadowing experience.

Regarding any patient or medical record information with respect to Drexel patients, I shall comply with all federal and state laws and regulations, and all rules, regulations, and policies of Drexel regarding the confidentiality of such information, including, without limitation, all applicable provisions and regulations of the HIPAA privacy rules.

I hereby apply for Shadowing/Observation at Drexel University Physicians and its

clinical practice sites from (start date) _____ to

(end date) _____.

Physician/Staff Person you will Shadow: _____

**PLEASE TYPE OR PRINT**

Full Name: _____

Present Address: _____

City:_____State:_____Zip:_____

Country: _____

Telephone: _____

E-Mail Address:_____Fax No.: _____

Permanent Address: _____

Place of Birth:_____Date of Birth: _____

Married_____Single_____

Citizen of:_____U.S. Social Security No.: _____

# Shadowing/Observership Agreement Form

I understand that I must comply with all policies and procedures of Drexel University Physicians including the need to produce TB testing records or to have, TB testing, and flu shot, and to complete and return the HIPPA self-learning test questions prior to shadowing/observership.

I further understand that failure to comply with all such Drexel policies and procedures may result in my dismissal from the shadowing program.

I agree that I seek this experience at my own risk and that I release Drexel from any liability or responsibility for any adverse event that might occur, such as a slip and fall.

_____ _____

Applicant Signature Date

I, _____ (physician/staff person) agree to allow candidate to shadow in accordance with policy and procedure.

_____ _____

Physician/Staff Person Signature Date

# Shadowing/Observership Confidentiality Statement

**The Health Insurance Portability and Accountability Act Privacy Regulations**

As of April 14, 2003, the federal Health Insurance Portability and Accountability Act (HIPAA) provides patient protections in connection with the use and disclosure of their health information, in addition to those protections that already exist under state law. Drexel University Physicians is committed to protecting the privacy and security of our patients' health information.

**By signing this statement, I acknowledge my responsibility under state and federal law and agree not to disclose or share with others, and keep confidential, any information regarding patients and proprietary information. I agree that if I have access to patient information, not to reveal any patient specific information, including that this person is a patient and any information I may learn about the circumstances of the patient's care, and further agree not to reveal to anyone else any confidential information of this organization. I agree to comply with any patient information privacy and security policies and procedures of the organization.**

I further acknowledge the importance of patient privacy, security and confidentiality, and that I have had an opportunity to ask questions regarding the privacy and security policies, procedures and practices.

**I have read and understand the terms of this statement and agree to abide by these terms.**

Should I choose to reveal confidential patient information to anyone, I acknowledge that the organization provided me with the applicable information and training in order to prevent any and all violations of the laws regarding patient privacy, security and confidentiality.

_____ _____

Applicant Signature Date

**Questions?** The address of Drexel University's Compliance Officer is 1505 Race Street, 13th Floor, Philadelphia, PA 19102 and you may contact the Privacy Office by telephone at 267-359-5597 or by email at Edward.Longazel@DrexelMed.edu.

## Patient Permission for Shadowing/Observation

Drexel University Physicians are a part of teaching institution and, as such, allows for observational experiences for those individuals pursuing a career in healthcare.

Observers will always be accompanied by a licensed physician and will never have direct patient contact. They will, however, be in the room during your examination as well as during any discussion with your physician.

If you are comfortable with allowing an observer during your examination, please complete the authorization below. If you are not comfortable, please complete the declination below. If you choose to decline, this will in no way affect the quality of care you receive today.

I will allow an observer during my visit _____

I will not allow an observer during my visit _____

_____

Patient's Signature Date