BON SECOURS CHARITY HEALTH SYSTEM
A member of the
Westchester Medical Center Health Network

Cover Sheet for Medical Staff Observations

This form is designed to assist in expediting the observation application process. In accordance with Bon Secours Charity Health System's policies, we are asking that the faculty/student submits all requested documentation in one complete packet.

Observers are prohibited from assisting with or participating in patient care in any way and prohibited from performing any function otherwise performed by members of the Medical Staff, Hospital staff/employees, vendors, contractors, or volunteers. BSCHS reserves the right to approve or decline any Observer applications. High school students or other lay persons are not permitted to observe in the hospital.

All Observation applicants are subject to a complete background check and **must return the required paperwork to the Medical Staff Office 4 weeks prior to beginning observation**. If approved, Observers will be required to attend an in-person interview with the Director of Medical Staff Services or designee.

Name of Student: _____ Date: _____

Student Email: _____ Phone: _____

Observation Contact: _____ Department: _____

Requested Start Date: _____ Requested End Date: _____
Not to exceed 6 months

School/Educational Institution: _____

School Contact/Coordinator: _____Email:_____

Phone:_____

I have reviewed the following information: http://bschs.bonsecours.com/nonemporient

□ Code of Conduct_____ □ Catholic and Religious Directives_____ □ Orientation Verification Attestation_____
Initials Initials Initials

I have attached the following documentation:
□ Cover Sheet for Medical Staff Observations
□ Request for Observation or Clinical Rotation Privileges
□ Confidentiality Agreement
□ Code of Conduct for Custodians of People with Special Needs
□ Observer and Clinical Rotation Orientation Verification
□ Health Assessment
□ PPD Results (within one year). If PPD positive, a chest x-ray report and complete PPD+ Reactor Questionnaire must be included. Negative QuantiFeron Gold is sufficient in lieu of PPD test.
□ MMR Titre: Rubella, Rubeola (Measles) Titre, if born after 1/1/1957
□ Flu Vaccine, if observing October 1 – May 15
□ Copy of Driver's License or a Federal ID with a picture
□ Two Letters of Recommendation from non-family members
□ College Students: Current / most recent college transcript
□ High School Students: Last Report Card
□ Personal statements regarding career goals, Observer objectives and prior relevant experience
□ Student Observers: Professional Conduct Agreement
□ Observers under the age of 18: Volunteer and/or Observer Parent/Legal Guardian Permission Slip

Submit this competed Cover Sheet with ALL required paperwork via Email

A representative from Bon Secours Charity Health System will contact the applicant for an in-person meeting prior to start of Observation, if approved. **Submit all forms to:**

Good Samaritan Hospital
Medical Student Education Coordinator
Charity_MedStudent@bshsi.org
845.368.5585 (office) 845.368-5938 (fax)

FOR OBSERVERS UNDER 18 YEARS OF AGE

BON SECOURS CHARITY HEALTH SYSTEM
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Volunteer and/or Observer
Parent/Legal Guardian Permission

I agree to allow my son/daughter, _____, to serve as a Volunteer or Observer at the following Bon Secours Charity facility:

- ☐ Bon Secours Community Hospital (Port Jervis, NY)
- ☐ Good Samaritan Hospital (Suffern, NY)
- ☐ St. Anthony Community Hospital & Campus (Warwick, NY)
- ☐ Bon Secours Medical Group (Goshen, NY)

I fully understand that in the course of his/her duties, my son/daughter may be permitted to enter patient areas of the hospital. I further understand that Bon Secours Charity Health System offers medical services for the care and treatment of a wide range of illnesses, infectious diseases and injuries. There is a risk, however slight, that my son/daughter might be inadvertently exposed to such circumstances at the hospital and or facility.

In consideration for their opportunity to Volunteer or Observe at Bon Secours Charity Health System, I release, discharge and relieve Bon Secours Charity Health System and its' employees from any and all claims whatsoever of any nature arising out of/as a result of his/her participation as a volunteer or observer with Bon Secours Charity Health System and all related activities.

I understand that he/she must participate in an Orientation, sign a confidentiality oath, and complete other required documentation as requested for Medical Staff clearance.

_____ _____
Parent/Legal Guardian Signature Date

Volunteer/Observer Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Emergency Contact Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

BON SECOURS CHARITY HEALTH SYSTEM
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STUDENT OBSERVER
Professional Conduct Agreement

All observers are expected at all times to conduct themselves in a positive manner that upholds the spirit of Code of Conduct and Ethical and Religious Directives in any Bon Secours Charity workplace. This means we are committed to adhering to the behaviors that demonstrate our health system values. The observer agrees not to disclose any personal, medical related information, or any other confidential information to third parties, family members etc. as defined in the Observer Confidentiality Agreement.

Behaviors:

- ❒ Communicate appropriately and respect those we serve who differ by gender, race, religion, culture, national origin, mental and physical abilities and sexual orientation. Treat them with dignity respect and compassion.
- ❒ Greet everyone with a smile and direct eye contact, and make sure that your ID badge is visible. Recognize that body language and tone of voice are important parts of communication.
- ❒ Dress appropriately in business casual clothing, socks/stockings are required (no scrubs, jeans, sneakers, shorts, short skirts, and open toed shoes). Be clean and professional in your appearance. Scrubs may be allowed, only if expressly permitted by Physician in charge.
- ❒ Cell phone use is strictly prohibited in all patient care areas. Limit personal use of cell phones to breaks and lunch times.
- ❒ Photography is strictly prohibited.
- ❒ Will not engage in any social media postings.
- ❒ Be an active listener and do not interrupt.
- ❒ Report all accidents or incidents promptly. Report any safety hazards you see immediately.
- ❒ Remain with the clinical provider that you are assigned to in all patient care areas.
- ❒ Observation experiences are not to be discussed outside the facility.
- ❒ Speak respectfully of the Bon Secours Charity Health System in the workplace and community.
- ❒ Honor your observation commitment. Make sure that you arrive on time with your ID.
- ❒ Observers are required to sign-in and out in the book found at the Information Desk.
- ❒ Many educational programs require documentation and proof of observation hours. Observers are responsible for tracking their hours by obtaining a signature on a date/time grid at the end of each shift. Letters from the Medical Staff Office will not be provided.
- ❒ The observer agrees to return their ID badge at the expiration of their observation experience.
- ❒ Observer understands and acknowledges that the time spent Observing is **NOT** a Clinical Rotation. Observer agrees that he or she will not represent the time spent Observing as a Clinical Rotation. _____(Observer's initials)

I acknowledge that I have reviewed the Professional Conduct Agreement and understand that I am accountable for knowing and exhibiting these behaviors. If I fail to meet the expectations outlined in this agreement it will be grounds for disciplinary action, including termination.

Signature: _____

Print Name: _____ Date: _____

****** Medical Staff Office Use Only******

Interviewed by: _____

Signature of Interviewer: _____ Date: _____

Medical Staff Office: Please provide a signed copy of this agreement to the observer.

Bon Secours Charity Health System

TUBERCULOSIS SCREENING: PPD+ REACTOR QUESTIONNAIRE

CONFIDENTIAL

Name (Print) _____

School: _____

Annual Screening ☐ Post exposure baseline ☐

Post Offer Screening ☐ Post exposure 8-10 wks ☐

During the past 12 months:	YES	NO	IF YES, PLEASE EXPLAIN
Have you been in contact with someone with TB this year?			
If yes, were you wearing a TB mask?			
Has your physician told you that your immune system is weak?			
Have you had a persistent cough this year?			
Have you had a cough lasting greater than 4 weeks?			
Have you had chest pain with the cough?			
Have you had a cough productive of phlegm?			
Have you coughed up blood?			
Has your voice been hoarse most of the year?			
Are you currently a cigarette smoker?			
If not, did you smoke in the past?			
Have you had night sweats?			
Have you had excessive weight loss?			
Have you had a loss of appetite?			
Have you had a persistent fever?			

Student's Signature: _____ Date: _____

Reviewed by: _____ Date: _____

Observer/Intern/Clinical Rotation Health Assessment Evaluation

BON SECOURS CHARITY HEALTH SYSTEM
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Name:_____ Date of Birth: _____

Required Health Documentation:

- PPD Results (within one year), If PPD positive, a Chest X-Ray report must be included.
- Negative QuantiFeron Gold is sufficient instead of a PPD Test.
- MMR Titre: Rubella, Rubeola (Measles) Titre, if born after 1/1/57,
- Flu Vaccine administered during flu season (Oct – May, or as directed by NYS DOH)

Do you have a physical, mental, or emotional condition or substance abuse problem that could affect your ability to observe safely?
☐ Yes ☐ No

Do you consider yourself to be in good health? ☐ Yes ☐ No

	Yes	No
Have you ever had a positive PPD (TB skin test)?		
Were you ever placed on medication for having a reaction to the PPD (TB skin test)?		
Have you ever received a BCG vaccine?		

TB and Immunizations

FOR PPD NEGATIVE REACTORS – Complete the PPD (Mantoux) test information below or submit equivalent form. New York State regulation 405.3 requires PPD (Mantoux) skin test within the last twelve (12) months.

Date administered: _____ Lot #: _____ Left or Right Forearm

Date read: _____ Results: _____ mm Induration (Indicate Zero if No Reaction)

Rubella Titer _____
Rubeola(Measles)Titer _____
(if born after 1/1/57)

Signature of Medical Professional (other than yourself): (or attach results from your Practitioner or School)

Signature: _____ Date: _____

Print Name: _____ Office Phone Number: _____

Email:_____

Observer/Clinical Rotation Student - Signature

I hereby state that the information provided on this form is complete, true and accurate.

Signature: _____ Date: _____

Print Name: _____

*** Medical Staff Office Use Only – Reviewed By ***

Signature: _____ Date: _____

Print Name: _____ Occupational Health Consult Requested: ☐ Yes ☐ No

OBSERVER and CLINICAL ROTATION ORIENTATION VERIFICATION

Please review the orientation documents by visiting our non-employee portal at:

Medical Staff Services Orientation and Reorientation:
http://bschs.bonsecours.com/nonemporient

Prepping for the OR*:
https://www.youtube.com/playlist?list=PLcRU-gvOmxE2mwMWkowouBkxGXkLZ8Uis

I have reviewed and understand the following provided to me through the non-employee portal:

_____ Medical Staff Services Orientation Module

_____ Code of Conduct

_____ Ethical and Religious Directives

_____ Sterile Technique

_____ Prepping for the OR – Sterile Technique Training (7 Videos)

Student Attestation:

_____ _____

Student Name – Printed **Student Name - Signature**

_____

Date:

*Surgical Infection Society, Filmed at the University of Alberta

Code of Conduct for Custodians of People with Special Needs

Introduction

The Code of Conduct, as set forth in the Code of Conduct itself, sets forth a framework intended to assist impacted employees to help people with special needs "live self-directed, meaningful lives in their communities, free from abuse and neglect, and protected from harm," in addition to the specific guidance provided by the agency's policies and training.

Similarly, the Notice to Mandated Reporters contains guidance designed to assist mandated reporters and is intended to provide a summary of reporting obligations for mandated reporters. It is not intended to supplement or in any way add to the reporting obligations provided by law, rule, or regulation.

As provided by law, rule, or regulation, only custodians who have or will have regular and direct contact with vulnerable persons receiving services or support from facilities or providers covered by the Justice Center Act must sign that they have read and understand the Code of Conduct.

The framework provides:

1. Person-Centered Approach

My primary duty is to the people who receive supports and services from this organization. I acknowledge that each person of suitable age must have the opportunity to direct his or her own life, honoring, where consistent with agency policy, their right to assume risk in a safe manner, and recognizing each person's potential for lifelong learning and growth. I understand that my job will require flexibility, creativity and commitment. Whenever consistent with agency policy, I will work to support the individual's preferences and interests.

2. Physical, Emotional and Personal Well-being

I will promote the physical, emotional and personal well-being of any person who receives services and supports from this organization, including their protection from abuse and neglect and reducing their risk of harm to others and themselves.

3. Respect, Dignity and Choice

I will respect the dignity and individuality of any person who receives services and supports from this organization and honor their choices and preferences whenever possible and consistent with agency policy. I will help people receiving supports and services use the opportunities and resources available to all in the community, whenever possible and consistent with agency policy.

4. Self-Determination

I will help people receiving supports and services realize their rights and responsibilities, and, as consistent with agency policy, make informed decisions and understand their options related to their physical health and emotional well-being.

5. Relationships

I will help people who receive services and supports from this organization maintain or develop healthy relationships with family and friends. I will support them in making informed choices about safely expressing their sexuality and other preferences, whenever possible and consistent with agency policy.

6. Advocacy

I will advocate for justice, inclusion and community participation with, or on behalf of, any person who receives services and supports from this organization, as consistent with agency policy. I will promote justice, fairness and equality, and respect their human, civil and legal rights.

7. Personal Health Information and Confidentiality

I understand that persons served by my organization have the right to privacy and confidentiality with respect to their personal health information and I will protect this information from unauthorized use or disclosure, except as required or permitted by law, rule, or regulation.

8. Non-Discrimination

I will not discriminate against people receiving services and supports or colleagues based on race, religion, national origin, sex, age, sexual orientation, gender identity, economic condition, disability, or any other protected class under the law.

9. Integrity, Responsibility and Professional Competency

I will reinforce the values of this organization when it does not compromise the well-being of any person who receives services and supports. I will maintain my skills and competency through continued learning, including all training provided by this organization. I will actively seek advice and guidance of others whenever I am uncertain about an appropriate course of action. I will not misrepresent my professional qualifications or affiliations. I will demonstrate model behavior to all, including persons receiving services and supports.

10. Reporting Requirement

As a mandated reporter, I acknowledge my legal obligation under Social Services Law § 491, as may be amended from time to time or superseded, to report all allegations of reportable incidents immediately upon discovery to the Justice Center's Vulnerable Persons' Central Register by calling 1-855-373-2122.

Code of Conduct[1] Acknowledgement for Custodians of People with Special Needs

I pledge to prevent abuse, neglect, or harm toward any person with special needs, consistent with agency policy. In addition, to the extent I am required to report abuse, neglect, or harm of any person with special needs by law, rule, or regulation, I agree to abide by the law, rule, or regulation. If I learn of, or witness, any incident of abuse, neglect or harm toward any person with special needs, I will offer immediate assistance, notify emergency personnel, including 9-1-1, and inform the management of this organization, consistent with agency policy.

I acknowledge that I have read and that I understand the Code of Conduct.

_____	_____	_____
Signature	Print Name	Date

Program: _____

Department: _____

Facility/Provider Organization: _____

[1]No aspect of this Code of Conduct is in any way intended to interfere, abridge, or infringe upon the rights provided by the Taylor Law.

Observer/Student Confidentiality Agreement

This Agreement (the "Agreement") is effective _____ day of _____, 20____,

Between_____facility") and _____ (Observer, Student),

to participate in clinical learning activities at facility. Observer agrees as follows:

Confidentiality Observer/Student acknowledges that as a result of the clinical learning activities, Observer/Student will have access to confidential information of the Facility, including patient health information. Observer/Student will hold confidential all patients and Facility information obtained as a participant in these activities and will not to disclose any personal, medical, related information, or any other confidential information to third parties, family members, or other Observers/s/Students and teachers, except as permitted in this Agreement or as required by law. Observer/Student is committed to protecting and safeguarding from any oral and written disclosure all confidential patient and Facility information that Observer/Students comes in contact with. Observer/Student shall not copy surgery schedules, patient medical records, or other Facility information. Except as permitted or required by this Agreement or by law, Observer/Student will not use or disclose patient information in a manner that would violate the laws of New York State or the requirements of any federal law, including, for example, the Privacy and Security Standards contained in the Health Insurance Portability and Accountability Act of 1996 (45 CFR §§ l60 through 164). Observer/Student expressly agrees to comply with state and federal law in all respects, and to implement of all necessary safeguards to prevent such disclosure. Observer/Student acknowledges that any breach of confidentiality or misuse of information will result in termination of Observer's clinical activities at Facility, as well as the potential termination of the Facility's relationship with Observer's/Students school or legal action. Unauthorized disclosure may give rise to irreparable injury to the patient or the owner of the confidential information and accordingly, the patient or owner of such information may seek legal remedies against the Observer/Student.

Compliance with Policies and Rules While participating in clinical activities at Facility, Observer/Student will abide by all applicable Facility rules, policies, procedures and instructions, whether verbal or written, including the Bon Secours Health System Code of Conduct. Observer/Student shall review the Facility's Administrative Policy Manual which includes information regarding bloodborne pathogens, hazardous chemicals, TB prevention, fire safety, electrical safety, and emergency preparedness. Observer/Student will wear appropriate attire, including an identification badge identifying him/her as an Observer/Student, as requested by Facility.

Release and Professional Liability Insurance Observer/Student will hold harmless the Facility, its parents, officers, directors, employees, members, and any and all of their affiliates, subsidiaries, employees, agents and insurers (collectively "Facility"), from any and all liability of whatsoever nature and from injuries, sickness or other damages, physical as well as emotional, suffered by Observer/Student during participation in the clinical activities. Observer/Student acknowledges that Observer/Student is covered by Observer's/Student own (or school's) professional liability insurance coverage and agrees to furnish proof of such coverage to Facility.

Limitation Observer/Student understands that by signing this Agreement, Observer/Student is not guaranteed participation in any clinical activities at Facility. Eligibility of participation shall be determined exclusively by Facility, in its sole discretion.

Withdrawal of Observer/Student Facility may require the Observer/Student to immediately withdraw from the clinical activities in the event Facility determines, in it sole discretion, that Observer/Student conduct, demeanor or cooperation is unsatisfactory or that Observer has violated Facility policies or rules, including, but not limited to, breach of confidentiality.

Observer/Student Status Observer/Student understands that Observer/Student is not and will not be considered an employee of Facility or any of its subsidiaries or affiliates by virtue of Observer's/Student's participation in the clinical learning activities and shall not as a result of Observer's/Student's participation in the clinical activities, be entitled to compensation, remuneration or benefits of any kind.

Observer/Student Signature:	Date
Medical Staff Services, Facility Representative:	Date

Medical Staff Services
Bon Secours Community Hospital • Good Samaritan Hospital
St. Anthony Community Hospital

BON SECOURS CHARITY HEALTH SYSTEM
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Request for Observation or Clinical Rotation Privileges

Date: _____

In the interest of furthering my education regarding _____, I

_____ request to ☐ observe or ☐ perform a clinical rotation with _____.

If performing a clinical rotation, please indicate the school name: _____.

** A current executed agreement with Bon Secours Charity Health System, WMC Health Network must be on file.*

Requested time period from: _____/_____/_____ to _____/_____/_____.

Specialty: _____

The following terms and conditions of my hospital experience and status apply:

1. Observers – Absolutely **no hands-on patient care is to be provided by me at any time**.
2. Patients under the care of the physician are to be notified of my status.
3. Patient confidentiality must be maintained at all times as stipulated by the rules and regulations established by the Confidentiality Agreement regarding patient privacy as outlined in Federal Law.
4. I release, discharge and relieve Bon Secours Charity Health System and its' employees from any and all claims whatsoever of any nature arising out of / as a result of his / her participation with Bon Secours Charity Health System and all related activities.

Student attestation:
I agree to the terms as outlined above.

_____ _____
Student Signature Date

_____ _____
Email Mobile Phone

_____ _____
Emergency Contact Name Phone

Licensed Independent Practitioner (LIP), Site Director or Preceptor attestation:
I understand the above named observer / student has been granted permission as set by the terms and conditions described above. I understand that Observers will provide no hands-on patient care at any time.

_____ _____
LIP, Site Director or Preceptor Print Name Date

_____
LIP, Site Director or Preceptor Signature

****

Authorized by:

_____ _____
System Director, Medical Staff Services or Designee, Print Name Date

_____
System Director, Medical Staff Services or Designee, Signature