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

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: _____

School contact name/phone/email: _____

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

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

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.

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

_____ _____
(Observer/Student, Signature) DATE

_____ _____
Email Cell Phone

_____
Emergency Contact Name & Telephone

Licensed Independent Practitioner (preceptor) attestation:
I understand the above named observer/clinical rotation 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.

_____ _____
(Licensed Independent Practitioner/Physician, (Print Name) DATE

_____
LIP/Physician Signature

Authorized by:

_____ _____
Director, Medical Staff Services or Designee (Print Name) DATE

_____
Director, Medical Staff Services or Designee Signature