UF UNIVERSITY of FLORIDA

REQUEST TO OBSERVE PATIENT CARE - UF Health Science Center and Affiliated Entities

OBSERVER INFORMATION	*Name:*	*Name and address of current institution, school, or employer*	
	Current Occupation:		
Type of Observers	☐ Visiting Scholar (clinical or otherwise) ☐ Faculty/staff applicant (usually staying for a few days) ☐ Student applicant ☐ Other:		
Area(s) to Observe:	☐ Teaching Hospital ☐ E.R. ☐ O.R. ☐ Other (clinic/institute name):		
Date Range	Starting by	Ending by	
Reason(s) for Observation	☐ Visiting Health Care Provider ☐ Career Planning ☐Required Course Work (describe below) ☐ Other:		
UF Dept. Contact	*Name:*	*Department:*	*E-mail:*
Sponsoring Faculty Submitting Request	*Name and Title:*		*Phone Number:*
	College:	*Department:*	*Division:*

Observer attests to the following:

☐ Completed HIPAA / Privacy General Awareness
☐ Signed Confidentiality Statement
☐ Will display an "observation ID badge" while observing
☐ Has received a flu shot within the past calendar year or will "mask up" in patient care areas.

Observer signature:

Observer Statement of Interest. *Please describe your reason(s) for requesting to observe care and how this experience will enhance your clinical knowledge. Attach a statement if necessary.*

Sponsoring Faculty Member specifically agrees that:

- Observer may not provide patient care, must be accompanied by UF/UFH staff, that patients have consented, and
- The Sponsoring Faculty Member assumes full responsibility for the actions of the Observer(s) and agrees to ensure that the Observer(s) complies with applicable UF / UF Health policies while observing care.

Signature of Faculty Member Sponsor: **Date of Request:**

Approved by Dean of College or Designee (signature):	*Date Approved:*	►►Return completed form plus attachments to:
Approved by UFH Shands Designee, if needed (signature):	*Date Approved:*	**Gainesville COM:** Sr. Assoc. Dean Clinical Affairs at Observe-UFHealth@ufl.edu **All Other Colleges:** UF Privacy Office at privacy@ufl.edu