City of Hope

MEDICAL STAFF SERVICES DEPARTMENT

REQUEST FOR VISITATION/OBSERVATION BY AN INDIVIDUAL WITH AN INTEREST IN HEALTHCARE (EXCLUDES VENDORS AND SALES REPRESENTATIVES)

On occasion, a Medical Staff Member may request an individual with an interest in healthcare to observe patient care practice at City of Hope (COH). The applicable Department Chair and the President of the Medical Staff will make a determination as to whether the request is reasonable and communicate the decision back to the requestor/Medical Staff Member. If the request is granted, the Medical Staff Member must notify COH's Medical Staff Services Department in advance and ask the Visitor/Observer to complete, sign and submit required forms (attached).

Name of Proposed Visitor/Observer: _____

Name of Medical Staff Member Sponsoring the Visit: _____

COH Location(s) Visited: ☐ Hospital - Specify Department/Main Treatment Area: _____

☐ Beckman Research ☐ Community Practice Site: _____

Anticipated Date(s) of the Visit: _____

☐ Written Explanation of Duties for Visitation-Rotations Lasting Longer than One Calendar Month (if applicable).

☐ OR Clinical Manager has Endorsed Rotation in the Operating Room (if applicable).

☐ A Non-Refundable $100 Application Processing Fee is Required for Practicing Physicians within the US; Foreign Observers; and COH Employees with an Interest in Pursuing a Career as a Medical Doctor.

Patient Consent Required: A visitor is permitted to be present or to observe a patient's diagnostic/therapeutic treatment or procedure only with prior approval from the Attending Medical Staff Member and the patient and acknowledgement by the clinical manager of the treatment area. The visitor must be introduced to the patient and the patient's verbal consent to the presence of the visitor must be obtained and documented in the medical record. This requirement promotes a safe clinical environment and avoids confusion regarding the visitor's status and role.

No Clinical Privileges/Observation Only/No Patient Care Activity/Non-Credit Activity: A visitor has no medical or allied health membership or privileges at COH Hospital. If this is desired, he/she must submit an application for appointment to the Medical Staff and independently qualify for membership in accordance with the Medical Staff Bylaws and the Rules and Regulations.

Duration of Rotation: The duration of an observational rotation will not exceed 30 days (one calendar month) per Calendar Year. A request seeking a rotation period greater than 30 days requires a written explanation for evaluation by (1) sponsoring Medical Staff member; (2) the appropriate Department Chair or Division Chief; (3) the Medical Staff President; and (4) the Chief Medical Officer Officer (for visitations at COHNMC only) or the Medical Director, Community Practice Sites (for visitations at Community Practice sites only). All must agree for the request to be granted.

Required Approvals:

SIGN HERE Department Chair or Designee	Date	Chief Medical Officer or Designee (For Hospital Visitations)	Date
Medical Staff President or Designee	Date	Medical Director, Community Practice Sites (For Community Practice Sites Visitations)	Date

City of Hope

DOCUMENTATION REQUIREMENTS FOR VISITORS/OBSERVERS ROTATING AT CITY OF HOPE (NON-CREDIT ACTIVITY)

INSTRUCTIONS: Please use this checklist to assist you in gathering the required information. When you have completed the information-gathering process, please sign the bottom of this form and submit it to the Medical Staff Services Department (MSSD) for final processing.

1. ☐ Students 16 to 18 Years of Age Must Have: (1) a Written Parental or Legal Guardian Consent; and (2) a Reference Letter from the Sponsoring COH Physician Member.
2. ☐ Letter of Agreement between Visitor/Observer and COH Sponsoring Physician.
3. ☐ Completed Health Forms (packet received by Human Resources).
4. ☐ Visitor/Observer Acknowledgement of Status & Confidentiality Statement.
5. ☐ Resume/Curriculum Vitae.
6. ☐ HIPAA Training (required if rotation is greater than 20 hours).
7. ☐ Corporate Compliance Training (required if rotation is greater than one calendar month).
8. ☐ A Non-Refundable $100 Application Processing Fee is Required for Practicing Physicians within the US; Foreign Observers; and COH Employees with an Interest in Pursuing a Career as a Medical Doctor.
   Check or Money Order Made Payable To: Medical Staff Services Department.

AN INCOMPLETE REQUEST FOR VISITATION/ROTATION WILL NOT BE PROCESSED

I have complied with the documentation requirements itemized above, as applicable.

SIGN HERE

_____ _____

Signature (Visitor/Observer) Date

City of Hope

LETTER OF AGREEMENT BETWEEN VISITOR/OBSERVER AND COH SPONSORING PHYSICIAN

Objective: The purpose of this agreement is to document the requirements/expectations of Sponsoring Physicians and visitors/observers as a condition to participate in an observation at City of Hope.

Name of Visitor and Title: _____

Date of Birth: _____ **Gender:** ☐ **Male** ☐ **Female**

Students 16 to 18 years of age must submit written parental or legal guardian consent, and a reference letter from the sponsoring COH physician member.

Referring Organization (if applicable): _____

Department/Division: _____

Dates of Anticipated Rotation: _____

The duration of an observational rotation will not exceed 30 days (one calendar month) per Calendar Year. A request seeking a rotation period greater than 30 days requires a written explanation for evaluation by (1) sponsoring Medical Staff member; (2) the appropriate Department Chair or Division Chief; (3) the Medical Staff President; and (4) the Chief Medical Officer Officer (for visitations at COHNMC only) or the Medical Director, Community Practice Sites (for visitations at Community Practice sites only). All must agree for the request to be granted. **A status report is required for observations in excess of 30 days.**

HIPAA training (required for rotations greater than 20 hours); Corporate Compliance training (required for rotations greater than one calendar month).

A non-refundable $100 application processing fee is required for practicing physicians within the US; foreign observers; and COH employees with an interest in pursuing a career as a medical doctor.

Operating Room (OR) Rotation at the COH Duarte-Campus: ☐ **Yes** ☐ **No**
The sponsoring physician must notify the OR manager in advance of potential observation so that the necessary accommodations can be made. OR rotations will be assessed based on patient volume.

I. Responsibilities of Sponsoring Physician:

I, _____, will assume administrative, educational and mentorship/ supervisory responsibility for _____, a visitor/observer at COH.

A. Administrative responsibilities include, but are not limited to the following:

1. Ascertain the visitors/observers necessary paperwork is completed and timely returned to the Medical Staff Services Department for processing, including medical clearance by Employee Health Services.

2. Orient and adequately inform the visitor/observer regarding applicable rules, policies, and procedures of City of Hope.
3. Assuring the proper conduct of the visitor/observer while at City of Hope.
4. Providing appropriate information to allow the visitor/observer to meet own goals and objectives for the experience.
5. Interacting with the referring organization in terms of feedback regarding the observational experience, as appropriate.

B. Observation in Clinical Setting:
The visitor/observer may be permitted to be present or to observe a patient's diagnostic/therapeutic treatment or procedure only with prior approval from the Attending Medical Staff Member and the patient. **The patient must be given the opportunity to decline in private. Once patient consent is obtained, the visitor must be introduced to the patient and the patient's verbal consent to the presence of the visitor must be documented in the medical record.** This requirement promotes a safe clinical environment and avoids confusion regarding the visitor's status and role.

C. Period of Assignment, No Financial Arrangements, and Medical Clearance:
The visitor/observer will participate in an observational experience during the duration of the approved observation rotation period only and will not be providing patient care. There is no financial exchange related to this experience. The visitor/observer must provide health information documentation that conforms to the requirements of COH in order to assure patient safety.

II. Responsibilities of Visitor/Observer:

A. The visitor/observer shall be required to comply with City of Hope policies and procedures, including Medical Staff Bylaws and Rules and Regulations (available on the COH Intranet).

B. The visitor/observer will not be reassigned to other clinical departments/divisions or assigned to additional types of duties without the express approval by the Medical Staff President and the Hospital's Chief Medical Officer (for rotations at COHNMC only) or the Medical Director, Community Practice Sites (for visitations at Community Practice sites only).

This agreement signifies your adherence to the terms and conditions in connection with visitation/observation experiences at the City of Hope.

SIGN HERE _____ _____
Visitor/Observer Date

SIGN HERE _____ _____
COH Sponsoring Physician Date

My signature below affirms that this Letter of Agreement accurately describes the agreement between the visitor/observer and the COH Sponsoring Physician.

SIGN HERE _____ _____
Department Chair Date

City of Hope

CONFIDENTIALITY REQUIREMENTS FOR OBSERVATION/VISIT

Obtaining Patient Approval of your Presence

As a visitor, you may be permitted to be present or to observe a patient's diagnostic/therapeutic treatment or procedure only with prior approval from the Attending Medical Staff Member and the patient. Your presence must also be accepted by the clinical manager of the treatment area. As a visitor, you must be introduced to the patient and the patient's verbal consent to your presence must be obtained.

Safeguarding Patient Health Information (PHI)

HIPAA's Privacy Rule requires you to "safeguard" PHI while you are shadowing a clinician at City of Hope. You must use the following practices to comply with the Privacy Rule:

- Speak quietly when you talk about patients as part of your observation; try to prevent others from overhearing the conversation.
- Whenever possible, hold conversations about patients in private areas.
- Do not discuss patients while you are in elevators or other public areas.
- Do not share or discuss names, patient or disease information or any other facts that could possibly identify a patient with anyone outside of City of Hope, including your family, friends and classmates, or social media.
- If you see a medical record in public view where patients or others can see it, report the matter to your sponsoring physician. The physician may cover the file, turn it over, or find another way to protect it.
- Never take copies of documents containing patient information, including any aspect of a patient's medical record from the City of Hope.

Use Only the Minimum Necessary Information

When you use PHI, you may only use or disclose the minimum amount or type of PHI necessary to achieve the goals of the use or disclosure. Ask yourself: "Is the PHI I am accessing necessary for the intended purpose?" or "Am I using or accessing more PHI than I need to?"

If you are unsure of the PHI you may use or access while shadowing providing health care for a patient at the City of Hope as a visitor/observer, please contact the Medical Staff Member sponsoring your visit, clinical manager in the specific treatment area, or the Privacy Officer.

I agree to abide by the aforementioned Confidentiality Requirements as it relates to PHI information. I also agree to comply with the City of Hope's Check-Out process, which includes the return of ID badge.

SIGN HERE

_____ _____

Signature of Visitor/Observer Date

City of Hope

VISITOR/OBSERVER ACKNOWLEDGEMENT OF STATUS & CONFIDENTIALITY STATEMENT

Name of Visitor/Observer _____

Sponsoring Medical Staff Member/Division _____

Date(s) of Visit _____

ACKNOWLEDGEMENT OF VISITOR/OBSERVER STATUS: I have requested status as a visitor/observer at City of Hope for the above referenced period. As a condition to my "visiting" status, I have signed the Confidentiality Statement below and received, read and agree to abide by **Section 29.3 of the Medical Staff Rules & Regulations**, which concerns **Visitors, Physicians, AHP Staff, and Others,** as follows:

On occasion, a Medical Staff Member may request an individual with an interest in healthcare to observe patient care practice at City of Hope. The President of the Medical Staff will make a determination as to whether the request is reasonable and communicate his or her decision back to the Medical Staff Member. If the request is granted, the Member must notify the Medical Staff Services Department in advance and provide the following information: (a) the name of the proposed visitor; (b) the name of the Medical Staff Member who is sponsoring the visit; (c) the anticipated date(s) of the visit; and (d) a written statement from the proposed visitor that (i) he/she has completed a health screening within the last year and will provide evidence of medical clearance; (ii) he/she will simply observe patient care and will not render any services at the Hospital or at the Community Practice sites, and (iii) he/she will maintain the confidentiality of all patient care records and information.

A visitor is permitted to be present or to observe a patient's diagnostic/therapeutic treatment or procedure only with prior approval from the Attending Medical Staff Member and the patient. The visitor must be introduced to the patient and the patient's verbal consent to the presence of the visitor must be obtained and documented in the medical record. This requirement promotes a safe clinical environment and avoids confusion regarding the visitor's status and role.

A visitor has no medical membership or privileges. If this is desired, he/she must submit an application for appointment and independently qualify for membership in accordance with the Medical Staff Bylaws and the Rules and Regulations.

If an approved visitor spends more than thirty (30) consecutive days at City of Hope, the applicable Department Chair is responsible for preparing a status report on the visit, to be submitted on a quarterly basis to the Credentials Committee for information.

CONFIDENTIALITY STATEMENT: I agree to respect and to maintain the confidentiality of all patient care records and information including discussions. I will not, at any time either during or subsequent to my visit, disclose to others, use, copy or permit to be copied without City of Hope's prior written consent, any confidential or proprietary information of City of Hope, including but not limited to, information which concerns patients, costs, or treatment methods not otherwise available to the public. I agree to comply with all federal and state laws and regulations regarding the confidentiality of patient-related information, including the Health Insurance Portability and Accountability Act ("HIPAA") and the Confidentiality of Medical Information Act ("COMIA"). I understand that the City of Hope and its Medical Staff are entitled to undertake such action as is deemed appropriate to ensure that confidentiality is maintained, including application to a court of law for injunctive or other relief in the event of a breach, or a threatened breach of this Statement.

SIGN HERE

_____ _____

Signature of Visitor/Observer Date

City of Hope

PERMISSION, CONSENT AND RELEASE FOR OBSERVATION/VISITATION OF A MINOR FOR EDUCATIONAL PURPOSES

I hereby grant permission and consent for my minor child _____ ("my child"), to participate in the Observational Rotation at City of Hope ("COH Program").

In granting my permission and consent, my signature below indicates that I understand and agree with each of the following statements:

☐ My child's participation in the COH Program is (i) strictly voluntary and (ii) for educational purposes only without contemplation of compensation of any kind.

☐ I agree on behalf of myself and my child to abide by applicable City of Hope policies and procedures.

☐ I acknowledge that I am legally responsible for any injury, loss or damage which occurs as a result of my child's participation in the COH Program.

☐ I release and discharge City of Hope and its affiliates, including their officers, directors, employees, contractors, and agents, from and against all claims, damages, losses and expenses (including attorney's fees), whether known or unknown, foreseen or unforeseen, that may arise out of or relating to my child's participation in the COH Program

☐ I am a legal resident of the United States living in the State of California and am 18 years of age or older.

_____
Print Name – Parent/Legal Guardian

_____ SIGN HERE
Signature – Parent/Legal Guardian

_____
Date

Please keep a copy of this form for your records and return the signed original to:

City of Hope
Medical Staff Services Department
1500 East Duarte Road
Duarte, CA 91010-3000