HUMAN RESOURCES

APPLICATION TO OBSERVE AT FLORIDA HOSPITAL

Please Type. Handwritten and / or Incomplete Applications will not be accepted.

APPLICANT STATUS				
☐ General / Business Student	☐ Allied Health Student	☐ Medical Student	☐ Pre-Med Student	☐ Resident
☐ Licensed Independent Practitioner	☐ Professional Interest	☐ Licensed Physician	☐ International Medical Graduate	☐ Other

APPLICANT INFORMATION		
Last Name	First	M.I.
Street Address		Apartment/Unit #
City	State	Zip
Gender ☐ M ☐ F	Date of Birth	Social Security No.
School or Program Name		Graduation Date
Home Phone	Mobile Phone	Email
Emergency Contact	Relationship	Phone

SPECIALTY REQUEST (IN ORDER OF PREFERENCE)			
Service/Department Preference:	First:	Second:	Third:
Preferred Dates:	First:	Second:	Third:

REASON FOR OBSERVATION REQUEST (PLEASE EXPLAIN WHY YOU ARE INTEREST IN THIS OBSERVATION OPPORTUNITY)

FLORIDA HOSPITAL PRECEPTOR (IF APPLICABLE)			
Last Name	First	M.I.	☐ MD ☐ DO

DISCLAIMER AND SIGNATURE

By signing this application,

- I request consideration for a period of observation at Florida Hospital
- I understand that I will not be permitted to engage in patient care.
- In the presence of a patient or in any patient care areas I will not be asked or allowed to answer specific questions about a patient's care or treatment, or otherwise provide medical or professional opinions.
- I understand that I will be expected to follow all of Florida Hospital's policies, rules and regulations, specifically those regarding infection control, safety and confidentiality.
- I agree to follow the directives of my sponsor. I understand that I must remain with him/her while in patient care areas.
- I understand that I am on Florida Hospital property at my own risk and insurance coverage, that I will not be indemnified / insured by Florida Hospital.
- I understand that if I breach any policies or obligations, my permission to act as an observer will be withdrawn and I may be asked to leave immediately.
- I certify that my answers are true and complete to the best of my knowledge. If this application is approved, I understand that I am responsible for submitting all required documents.

Applicant Signature	Date

Please fax application to FH HR Compliance at 407-200-4959 or email linda.archer-hislop@flhosp.org

FOR FLORIDA HOSPITAL SPONSORING DEPARTMENT USE ONLY

APPROVAL DATES		
Specialty	Start Date	End Date

FH SPONSOR / PRECEPTOR STATEMENT (PLEASE TYPE)

As a FH employee and/or a member of the Medical Staff with appropriate privileges for procedures. I endorse the applicant to complete the approved observership at Florida Hospital. This applicant will be under my full supervision. I have reviewed the application and credentials submitted by this applicant to be an Observer at Florida Hospital. By my signature I agree to the following:

- I support the application and agree to personally oversee and supervise this individual during the approved period of observation.
- The Observer will abide by Florida Hospital's policies, and will review the hospital's rules for Patient Confidentiality and Standard Precautions.
- I understand that the Observer is permitted only to view patient care, and only with patient consent. I agree that the Observer will have no direct patient contact or provide any type of medical care.
- The Observer will wear his/her identification badge at all times while in the Hospital.
- The Observer will follow good hand washing practices while at the Hospital, specifically after using the bathroom, and upon entering or leaving a patient care area. The Observer will not enter isolation rooms, and will not come to observe when he/she is sick, has a fever, or has been exposed to a contagious disease.

Last Name	First	M.I.	☐ MD ☐ DO	
Street Address	City	State	Zip	Suite/Unit #
Specialty	Business Phone	Business Fax		
Mobile Phone	E-mail Address			
Preceptor Signature			Date	

FH DEPARTMENT (FOR FH SPONSORING DEPT. USE ONLY)

The applicant is:	☐ Approved	☐ Declined
The applicant may:	☐ Observe Only	

FH Dept. Mgr/Dir. Signature / Physician/Residency Coordinator* Signature	Date
FH Dept. Coordinator / GME Representative* Signature	Date

*Applicable to GME only