

## **OU Medicine Observation Checklist**

Medical Staff/Credentialing Services

1200 Everett Drive, Room 2315

Oklahoma City, OK 73104

Phone 405-271-3741

Fax 405-271-3602

[OUMSCREDENTIALING@OUMEDICINE.COM](mailto:OUMSCREDENTIALING@OUMEDICINE.COM)

A **new request** for an observation packet **must be made each time** a Practitioner is requesting an observation/shadow approval at OU Medicine. Contact the Medical Staff/Credentialing Services Department at 405-271-3741 and request an observation packet.

These forms are subject to change at any time and we want to ensure you have the most current and up to date forms needed. Return completed documentation to fax or email listed above.

### **This information is required-no exceptions:**

1. \_\_\_\_ Completed Physician/Resident Observer-Shadow Information Form (2 pages)
2. \_\_\_\_ Completed Physician/Resident Observer-Shadow Permission Form signed by the Sponsoring Physician and the Physician/Resident Observer
3. \_\_\_\_ Signed/dated Confidentiality and Security Agreement Form
4. \_\_\_\_ Signed/dated OU Medicine Excel Form
5. \_\_\_\_ Ebola Observation Questionnaire
6. \_\_\_\_ Current TB documentation (within the previous 12 months) Documentation must include: Date test read, Name/title of qualified person reading test, Lot number of test administered, and Results. Any positive result must be followed up with chest x-ray indicating no current infection.
7. \_\_\_\_ Current Influenza immunization documentation (within the current flu season) OR acknowledgement checked on Information Form that Observer will wear a mask in patient care or procedure areas during the Flu Season.
8. \_\_\_\_ Copy of a Government Issued Photo ID (example: Passport, Driver's License)
9. \_\_\_\_ If not a US citizen, in addition to Government Issued Photo ID submit a copy of Visa or Electronic System for Travel Authorization Application Approval (Visa Waiver Program), or for Canadian visitors a copy of the I-94 form.



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## **Physician/Resident Observer-Shadow Information Form**

**This form is for Physicians only requesting to observe at OUM and must be filled out in its entirety and sign/date the bottom of the second page. If you are not a Physician, please contact our office as you may need to go through a different department for your request.**

Name: \_\_\_\_\_  
(First) (Middle) (Last)

Contact Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

SSN or Passport Number: \_\_\_\_\_

United States Citizen? (Yes or No) \_\_\_\_\_

Medical License # \_\_\_\_\_ State or Country of Licensure \_\_\_\_\_

Discipline/Clinical Service Requested: \_\_\_\_\_

Attending Physician to be Observed: \_\_\_\_\_

Attending Physician Contact Number: \_\_\_\_\_

Date Range of Observation/Shadow: From-\_\_\_\_\_ To-\_\_\_\_\_

Reason for Observation/Shadow \_\_\_\_\_

Have you applied or will you be applying for Medical Staff Membership and Privileges? \_\_\_\_\_

### Attestation of Immunization

I attest that I have received immunization for or have had the disease of measles, mumps, rubella, varicella.

\_\_\_\_\_ I have **received** the Hepatitis B Vaccination

\_\_\_\_\_ I have **declined** the Hepatitis B Vaccination

Date of most recent Influenza Vaccination: \_\_\_\_\_

*Proof of current Influenza documentation must accompany request if the observation occurs anytime during the current flu season (November 1 through April 15; or the declination below must be marked and mask worn in all patient care areas.*

\_\_\_\_\_ I have not received an Influenza Vaccination within the past year and understand I must wear a mask in all patient care areas of the facilities during Flu Season (November 1 thru April 15)

Date of Tuberculosis testing within previous 12 months: \_\_\_\_\_ Result: \_\_\_\_\_

*Proof of current TB including results within the previous 12 months must accompany request; if results are positive please also provide copy of Chest X-ray indicating no current infection and answer the risk assessment below.*

\_\_\_\_\_ I have had a Past Positive PPD Test and do not take the PPD Test. If yes, please complete Past Positive Tuberculin Questionnaire below and provide copy of Chest X-ray completed within the previous 2 yrs.

RISK ASSESSMENT: (Check box Yes or No)

During the past 12 months, have you had (please check Yes or No):

Yes ___ No ___	Persistent cough of > 3 weeks
Yes ___ No ___	Fever or night sweats
Yes ___ No ___	Unexplained Weight Loss
Yes ___ No ___	Bloody sputum
Yes ___ No ___	Frequent chest colds or pneumonia
Yes ___ No ___	Have you previously taken Medication for tuberculosis
Yes ___ No ___	Do you currently smoke?

If yes, how many cigarettes per day? \_\_\_\_\_

For how many years? \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician/Resident Observer Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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## **Physician/Resident Observer-Shadow Permission Form**

### **Physician Observation/Shadow Program Information**

***Please note that it is the sole responsibility of the practitioner applying for the physician observation/shadow program to make arrangements to observe/shadow a credentialed OU MEDICINE Physician. OU MEDICINE will not facilitate the arrangements between the practitioner and the Physician.***

**Please fill out the following contact information:**

Physician Observer/Shadow Name: \_\_\_\_\_

Physician Observer/Shadow Cell Phone/Pager: \_\_\_\_\_

Physician Observer/Shadow E-mail Address: \_\_\_\_\_

Date(s) of Observation/Shadow: From: \_\_\_\_\_ To: \_\_\_\_\_

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### **SPONSORING PHYSICIAN INFORMATION**

Sponsoring Physician to be observed: \_\_\_\_\_

Sponsoring Physician Department: \_\_\_\_\_

Sponsoring Physician Office Number: \_\_\_\_\_

Sponsoring Physician Cell Phone/Pager: \_\_\_\_\_

Sponsoring Physician E-mail Address: \_\_\_\_\_

**Sponsoring Physician Printed Name:** \_\_\_\_\_

**Sponsoring Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## AUTHORIZATION FOR RELEASE

### Physician Observer/Shadow Medical Release

In consideration of acceptance of the Physician Observer/Shadow to participate in the Physician Observation/Shadow Program, I hereby waive any and all claims for myself and my heirs against OU MEDICINE and all sponsors of the program, for injury or illness which may directly or indirectly result in my participation. I further agree to save and hold said parties harmless and agree to indemnify each of said persons against all liability for any loss, cost, injury or damage to persons or property, which may arise by virtue of engaging in the Physician Observation/Shadow Program. I am in proper physical condition to participate in this program.

I understand that while I'm in attendance in the Physician Observation/Shadow Program, I may be photographed and/or filmed. I grant OU MEDICINE the exclusive right to tape, broadcast, use, sell or photograph and all other electronic or mechanical reproduction in connection with the Physician Observation/Shadow Program, of myself alone or with other persons, together with alterations or edited version of the foregoing.

**Physician Observer/Shadow Name:** \_\_\_\_\_

**Medical Institution/School:** \_\_\_\_\_

**Physician Observer/Shadow Signature:** \_\_\_\_\_

**If this release is not signed, you will not be allowed to participate in the Physician Observation/Shadow Program.**

#### TO BE COMPLETED BY MEDICAL STAFF/CREDENTIALING DEPT.

\_\_\_\_\_ Government Issued ID Copied  
\_\_\_\_\_ Observation/Shadow Packet Completed  
\_\_\_\_\_ Attest to Immunizations Completed  
\_\_\_\_\_ Attending Physician Permission Form Completed  
\_\_\_\_\_ ID Badge Issued w/ date range of Approval  
\_\_\_\_\_ Copy of ID Badge once printed  
\_\_\_\_\_ Attending Physician notified of approval: Date notified: \_\_\_\_\_  
\_\_\_\_\_ Physician Observer/Shadow notified of approval: Date notified: \_\_\_\_\_

Comments:

Credentialing Coordinator Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name:



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### **Confidentiality and Security Agreement**

***Note: this form to be used for OU Medicine employees and workforce members.***

I understand that OU Medicine (the "Company") for which I work, volunteer or provide services manages health information as part of its mission to treat patients. Further, I understand that the Company has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their patients' health information.

Additionally, the Company must assure the confidentiality of its human resources, payroll, fiscal, research, internal reporting, strategic planning information, credentialing, intellectual property, or any information that contains Social Security numbers, health insurance claim numbers, passwords, PINs, encryption keys, credit card or other financial account numbers (collectively, with patient identifiable health information, "Confidential Information").

In the course of my employment/assignment at the Company, I understand that I may come into the possession of this type of Confidential Information. I will access and use this information only when it is necessary to perform my job related duties in accordance with the Company's Privacy and Security Policies, which are available on the Company intranet. I further understand that I must sign and comply with this Agreement in order to obtain authorization for access to Confidential Information or Company systems.

#### **General Rules**

1. I will act in the best interest of the Company and in accordance with its Code of Conduct at all times during my relationship with the Company.
2. I understand that I should have no expectation of privacy when using Company information systems. The Company may log access, review, and otherwise utilize information stored on or passing through its systems, including email, in order to manage systems and enforce security.
3. I understand that violation of this Agreement may result in disciplinary action, up to and including termination of employment, suspension, and loss of privileges, and/or termination of authorization to work within the Company, in accordance with the Company's policies.

#### **Protecting Confidential Information**

4. I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know it. I will not take media or documents containing Confidential Information home with me unless specifically authorized to do so as part of my job.
5. I will not publish or disclose any Confidential Information to others using personal email, or to any Internet sites, or through Internet blogs or sites such as Facebook or Twitter. I will only use such communication methods when explicitly authorized to do so in support of Company business and within the permitted uses of Confidential Information as governed by regulations such as HIPAA.
6. I will not in any way divulge, copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized. I will only reuse or destroy media in accordance with Company Information Security Standards and Company record retention policy.
7. In the course of treating patients, I may need to orally communicate health information to or about patients. While I understand that my first priority is treating patients, I will take reasonable safeguards to protect conversations from unauthorized listeners. Such safeguards include, but are not limited to: lowering my voice or using private rooms or areas where available.
8. I will not make any unauthorized transmissions, inquiries, modifications, or purgings of Confidential Information.
9. I will not transmit Confidential Information outside the Company network unless I am specifically authorized to do so as part of my job responsibilities. If I do transmit Confidential Information outside of the Company using email or other electronic communication methods, I will ensure that the Information is encrypted according to Company Information Security Standards.

#### **Following Appropriate Access**

10. I will only access or use systems or devices I am officially authorized to access, and will not demonstrate the operation or function of systems or devices to unauthorized individuals.



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11. I will only access software systems to review patient records or Company information when I have a business need to know, as well as any necessary consent. By accessing a patient's record or Company information, I am affirmatively representing to the Company at the time of each access that I have the requisite business need to know and appropriate consent, and the Company may rely on that representation in granting such access to me.

#### **Using Mobile Devices, Portable Devices and Removable Media**

12. I will not copy or store Confidential Information on mobile devices, portable devices or removable media such as laptops, personal digital assistants (PDAs), cell phones, CDs, thumb drives, external hard drives, etc., unless specifically required to do so by my job. If I do copy or store Confidential Information on removable media, I will encrypt the information while it is on the media according to Company Information Security Standards.
13. I understand that any mobile device (Smart phone, PDA, etc.) that synchronizes company data (e.g., Company email) may contain Confidential Information and as a result, must be protected as required by Company Information Security Standards.

#### **Doing My Part – Personal Security**

14. I understand that I will be assigned a unique identifier (e.g., 3-4 User ID) to track my access and use of Confidential Information and that the identifier is associated with my personal data provided as part of the initial and/or periodic credentialing and/or employment verification processes.
15. I will:
- Use only my officially assigned User-ID and password
  - Use only approved licensed software.
  - Use a device with virus protection software.
16. I will never:
- Disclose passwords, PINs, or access codes.
  - Allow another individual to use my digital identity (e.g., 3-4 User ID) to access, modify, or delete data and/or use a computer system.
  - Use tools or techniques to break/exploit security measures.
  - Connect unauthorized systems or devices to the Company network.
17. I will practice good workstation security measures such as locking up diskettes when not in use, using screen savers with activated passwords, positioning screens away from public view.
18. I will immediately notify my manager, Facility Information Security Official (FISO), Director of Information Technology, or Facility help desk if:
- my password has been seen, disclosed, or otherwise compromised;
  - media with Confidential Information stored on it has been lost or stolen;
  - I suspect a virus infection on any system;
  - I am aware of any activity that violates this agreement, privacy and security policies; or
  - I am aware of any other incident that could possibly have any adverse impact on Confidential Information or Company systems.

#### **Upon Termination**

19. I agree that my obligations under this Agreement will continue after termination of my employment, expiration of my contract, or my relationship ceases with the Company.
20. Upon termination, I will immediately return any documents or media containing Confidential Information to the Company.
21. I understand that I have no right to any ownership interest in any Confidential Information accessed or created by me during and in the scope of my relationship with the Company.

By signing this document, I acknowledge that I have read this Agreement and I agree to comply with all the terms and conditions stated above.

Employee/Workforce Member Signature		Date
Employee/Workforce Member Printed Name	Vendor Name (if applicable)	





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## WE WILL EXCEL

### PROFESSIONALISM - CARING - COMMUNICATION - QUALITY - INNOVATION

#### We approach our work in a professional manner:

- I will model integrity by being honest and trustworthy in my work.
- I will promote accountability by being responsible for my own actions.
- I will discuss confidential and personal information in a private area.
- I will work together with my colleagues to achieve our common goals.
- I will demonstrate respect by treating others as I would expect to be treated.
- I will treat our facilities and equipment as I would treat my own.
- I will be on time for work, meetings and other commitments.
- I will abide by the organization's dress code.
- I will accept constructive feedback.

#### We believe effective communication is fundamental to everything we do:

- I will introduce myself to patients, families, visitors and colleagues.
- I will explain the expected duration of procedures, visits and delays to patients.
- I will share appropriate information with people in a timely manner.
- I will communicate effectively by speaking clearly and actively listening while learning and sharing information.
- I will wear my ID badge where it can easily be seen.
- I will communicate effectively through all levels of our organization.
- I will communicate with sincerity, honesty and cultural understanding.

#### We are sensitive to the needs of those we serve:

- I will always act with compassion, kindness, empathy and patience.
- I will be respectful and courteous to everyone because they are important to our organization.
- I will make myself available to those in need. I will respect cultural, religious and social backgrounds.

#### We are committed to quality service:

- I will be committed to understanding and applying best practices.
- I will continually review my performance and strive to improve myself and the outcome of my work.
- I will be committed to everyone's safety.
- I will pursue my duties to completion.
- I will strive to be helpful in every situation.
- I will demonstrate and encourage positive behaviors.

#### We always look for better ways to take care of our patients:

- I will take pride and ownership in innovation within OU Medicine by committing to new technology and research.
- I will be committed to developing new knowledge and sharing it with others.
- I will promote innovation that will benefit those we serve.
- I will actively support, mentor and coach to foster a constructive learning environment.
- I will pursue opportunities to learn and grow

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name





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Dear Practitioner,

OU Medicine is continuing to provide training and resources to address needs brought about by the current Ebola events. Because we place patients, employees, and practitioners as our highest priorities, we are requesting that you provide information that will help us in our planning and response to this public health challenge.

Name: \_\_\_\_\_

1. Have you shadowed or observed at any facility that had a confirmed EVD patient at any time in the last 21 days?

Yes \_\_\_\_\_ No \_\_\_\_\_

a. If yes, when and in what units? \_\_\_\_\_

- b. If yes, did you provide care to a patient with suspected or confirmed EVD?

Yes \_\_\_\_\_ No \_\_\_\_\_

2. Have you had close personal contact with anyone else who worked at any facility who had a confirmed EVD patient?

a. Yes \_\_\_\_\_ No \_\_\_\_\_

b. If yes, please describe the nature of the contact: \_\_\_\_\_

3. Have you traveled to the identified West African countries or had close personal contact with someone who has within the past 21 days?

a. Yes \_\_\_\_\_ b. No \_\_\_\_\_

Thank you for your candid responses to these questions.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_