DOAR & Affiliates
Student Observation Request Form

Instructions to Student:

1) Determine Location/Facility you would like to observe. See www.doarpt.com/locations.
2) Complete this form.
3) Sign and attach Exhibit A to this request.
4) Complete HIPAA training. Attach documentation of training completion to this request.
5) Sign and attach Exhibit B to this request.
6) Submit request with attachments to the Location Manager for review/approval.

Student Name: _____ DOB: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Street Address: _____

City: _____ State: _____ Zip: _____

School: _____

Level of Student: _____ Expected Graduation Date: _____

If Student is a Minor, Parent or Legal Guardian Name: _____

Home Phone: _____ Cell Phone: _____

Emergency Contact Name: _____

Relationship to Student: _____

Home Phone: _____ Cell Phone: _____

Location/Facility Requested: _____

Specific Hours/Days Requested: _____

Start Date Requested: _____ End Date Requested: _____

Note: Observations are designed to be short-term (less than 2 weeks) and do not include hands-on experience.

Purpose of Observation: _____

_____

_____

_____

_____

REQUEST APPROVAL – TO BE COMPLETED BY LOCATION MANAGER

Location/Facility: _____

Student Preceptor: _____

Specific Hours/Days: _____

Start Date:_____ End Date: _____

Location Manager Signature: _____ Date: _____

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Exhibit A

Observation Only

Responsibility And Confidentiality Statement

For and in consideration of the benefit provided the undersigned in the form of experience in evaluation and treatment of patients of _____ ("Facility"), the undersigned and his/her heirs, successors and/or assigns do hereby covenant and agree to assume all risks of, and be solely responsible for, any injury or loss sustained by the undersigned while participating in the observation at Facility unless such injury of loss arises solely out of Facility's gross negligence or willful misconduct.

My sponsoring facility, academic facility, employer or I have personally provided evidence of my professional and/or general liability insurance to the Facility department authorizing my observation activity. If I do not provide evidence of insurance, I am personally liable for all injury, illnesses, or damages to myself or others related to my participation in this event. I hereby release, hold harmless, acquit, and forever discharge the Facility, Center for Pediatric Therapies, Inc., All Care Home Health, Inc., Accelerated Care, Inc., Martinsville Physical Therapy & Industrial Rehabilitation, Inc., Danville Orthopedic & Athletic Rehabilitation, Inc., and each of these entities, their agents, servants, successors, or assigns, for any and all actions, causes of action, claims, demands, damages, costs, expenses, any present or future healthcare charges related or unrelated to medical treatment and compensation, arising out of, or related in any way to my observation in patient care areas in this Facility or its associated entities.

In addition, the undersigned agrees to:

1. Abide by the Policies and Procedures of the Facility;

2. Comply will all applicable federal, state and local statutes and regulations in connection with the observation;

3. Obtain prior written approval from the Facility before publishing any materials relating to the observation.

The undersigned hereby acknowledges her/her responsibility under applicable Federal law to keep confidential any information regarding Facility patients, as well as all confidential information of Facility. The undersigned agrees, under penalty of law, not to reveal to any person or persons except authorized clinical staff and associated personnel any specific information regarding any patient and further agrees not to reveal to any third party any confidential information of Facility, except as required by law or as authorized by Facility.

_____

Observation Participant Name Date

_____

Observation Participant Signature Date

_____

Parent or Guardian Name if Participant is a Minor Date

_____

Parent or Guardian Signature if Participant is a Minor Date

_____

Witness Name Date

_____

Witness Signature Date

_____

Location Manager Signature Date

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Exhibit B

Confidentiality Statement

The Health Insurance Portability and Accountability Act Privacy Regulations

As of April 14, 2003, the federal Health Insurance Portability and Accountability Act (HIPAA) provides patient protections in connection with the use and disclosure of their health information, in addition to those protections that already exist under state law. _____ ("Facility"), are committed to protecting the privacy and security of our patients" health information.

By signing this statement, I acknowledge my responsibility under state and federal law and agree not to disclose or share with others, and keep confidential, any information regarding Facility patients and proprietary information of Facility. I agree that if I have access to patient information, not to reveal to any patient specific information, including that this person is a patient at the Facility and any information I may learn about the circumstances of the patient's care, and further agree not to reveal to anyone else any confidential information of this Facility. I agree to comply with any patient information privacy and security policies and procedures of the Facility. I further acknowledge that the importance of patient privacy, security and confidentiality has also been verbally discussed with me, and that I had an opportunity to ask questions regarding the Facility's privacy and security policies, procedures and practices.

I have read and understand the terms of this statement and agree to abide by these terms. Should I choose to reveal confidential patient information to anyone. I acknowledge that the Facility provided me with the applicable information and training in order to prevent any and all violations of the laws regarding patient privacy, security and confidentiality.

_____
Observation Participant Name Date

_____
Observation Participant Signature Date

_____
Parent or Guardian Name if Participant is a Minor Date

_____
Parent or Guardian Signature if Participant is a Minor Date

_____
Witness Name Date

_____
Witness Signature Date

_____
Location Manager Signature Date