YALE NEW HAVEN HEALTH / Application for Medical Staff Observers*	
NAME:	
DATES of OBSERVATION REQUESTED:	
Relevant YALE NEW HAVEN HEALTH Hospital *(check as applicable)*	☐ Bridgeport ☐ Greenwich ☐ Lawrence + Memorial ☐ Westerly ☐ Yale New Haven
Please describe the Purpose / intent of Observation:	
NAME OF MEDICAL STAFF SPONSOR:	
DEPARTMENT / SECTION:	

Attestation

The individual listed has requested to visit the YALE NEW HAVEN HEALTH Affiliated hospital identified above strictly as an observer for the period of time and purpose indicated. I agree that I will be responsible for this individual and he/she will be accompanied at all times by a member of the Medical Staff while he/she is on the premises of the hospital indicated.

We agree and understand that, if approved as an observer, the applicant is permitted to observe patient care only and that he/she will have no patient contact. To this end, he/she will be prohibited from engaging in any of the following: speaking with or examining patients, providing opinions or consultation about any patient hospitalized at the YALE NEW HAVEN HEALTH Affiliated hospital or reading, writing or documenting directly or indirectly in any patient medical records. If approved as an observer in the operating rooms or other procedural areas, the applicant understands that he/she must remain unscrubbed at all times.

The applicant agrees:

- to display appropriate identification while on YALE NEW HAVEN HEALTH Hospital premises;
- that the attached immunization testing record is complete and accurate;
- to fulfill documentation requirements as stipulated in the attached letter; and
- to sign and return the Confidentiality Agreement to Medical Staff Administration

Medical Staff Member's Signature		Observer's Signature	
Date		Date	

PLEASE FAX COMPLETED DOCUMENTS TO: 203-688-5343

*Note: Practitioners who wish to participate in patient care may apply as a "Guests." Applications are available by contacting Medical Staff Administration at 203-688-2615.

Medical Staff Administration

Reviewed by: _____ Comments: _____

Date: _____ _____

YALE NEW HAVEN HEALTH
Medical Staff Observer
Confidentiality Agreement

I understand that in my capacity as a Medical Staff Observer, I may become aware of confidential information such as:

- Patient health care and financial information (otherwise known under HIPAA as "Protected Health Information")
- Employee health care information
- Medical Staff information
- Business information related to YALE NEW HAVEN HEALTH Affiliated Hospitals (including financial, administrative, resource management and other information)

By signing below, I agree to the following:

a. I understand that access to the information noted above in a verbal, written or electronic (stored in a computer) form is a privilege. I also understand that access to any YALE NEW HAVEN HEALTH information is granted to me based solely on a clinical "need to know" basis depending upon the limitations of my approved level of involvement in patient care activities at the YALE NEW HAVEN HEALTH Affiliated Hospital where I am approved to observe.

b. I agree that I will not share with others any information about any patient, including the name or address of the patient or the fact that the individual is or was a patient at a YALE NEW HAVEN HEALTH Affiliated Hospital. I will not share this information with my colleagues, family, friends or anyone not directly involved in the care of the patient.

c. I understand that any photography, video or audio recording is prohibited and will result in immediate revocation of my appointment. For Medical Staff Observers: I understand that I may be privy to information on patients who are under the care of the Medical Staff Member to whom I am assigned.

d. I understand that patient information may <u>not</u> be used by me for research or teaching purposes unless authorized by the appropriate institutional review board and in compliance with YALE NEW HAVEN HEALTH Policies and Procedures.

e. I understand that the methods I use to get information may only be used relative to my limited role as a Medical Staff Observer. I understand that I may <u>not</u> use the personal identification number, sign-on code, password, physical token device of any person at any time. I understand that **violation of this Agreement** may result in possible legal action, fines or criminal prosecution against me.

f. I understand that I may not seek access to any information that is not authorized under the scope of my role as a Medical Staff Observer. I understand that patient information accessed via computer is considered the equivalent to the patient's medical record and may not, under any circumstances, be re-disclosed without proper authorization as covered in the applicable YALE NEW HAVEN HEALTH Affiliated hospital's Medical Staff Bylaws and Rules & Regulations.

g. I agree to access, use, store and dispose of information which I am authorized to access in a manner that ensures continued security and confidentiality in accordance with YALE NEW HAVEN HEALTH Policies & Procedures.

h. I understand that computer hardware, software, and information are considered YALE NEW HAVEN HEALTH property and are subject to and protected by appropriate YALE NEW HAVEN HEALTH Policies & Procedures.

i. I understand that YALE NEW HAVEN HEALTH reserves the right to make modifications to its program concerning access to Protected Health Information.

j. I understand that my ability to serve as a Medical Staff Observer will be automatically rescinded in the event of violation of any of the above. In addition, violation of this Agreement may result in possible legal action, fines or criminal prosecution against me and, as applicable, the organization I represent.

k. I agree to indemnify and hold YALE NEW HAVEN HEALTH and its Affiliated hospitals harmless from and against any and all claims, losses, costs and expenses including, reasonable attorneys' fees, related to or arising from any violation of the terms of this Agreement.

Printed Name:	
Signature:	
Date:	

YALE NEW HAVEN HEALTH
IMMUNIZATION TESTING RECORD

NAME: _____ D.O.B.: _____
DEPARTMENT: _____ DATE: _____

DOCUMENTATION OF IMMUNIZATIONS/TITERS		
	DATES of vaccine or titer	**TITER RESULT**
MEASLES VACCINE (dates for both doses) **or**		N/A
MEASLES TITER (if no vaccine)		
RUBELLA VACCINE (dates for both doses) **or**		N/A
RUBELLA TITER (if no vaccine)		
MUMPS VACCINE (dates for both doses) **or**		N/A
MUMPS TITER (if no vaccine)		
VARICELLA VACCINE received (2 doses of Varivax) **or**		N/A
History of physician-diagnosed illness (chicken pox, herpes-zoster)		N/A
VARICELLA TITER (if neither of the above)		
TETANUS-DIPTHERIA-PERTUSSUS VACCINE received (must be since 2005)		N/A
TB SKIN TEST (negative within past 12 months) **or**		N/A
IGRA (negative within past 12 months)		N/A
INFLUENZA VACCINE (annual)		N/A
COVID-19 VACCINE (dates for doses and brand of vaccine) ALSO UPLOAD IMAGE OF VACCINATION CARD OR DOCUMENTATION FROM ELECTRONIC MEDICAL RECORD		N/A

PPD or IGRA Positive

If **PPD/IGRA** positive, did you have a chest x-ray: **YES** ☐ (please include results) **NO** ☐

If **PPD/IGRA** positive, did you receive prophylactic anti-tuberculosis therapy? **YES** ☐ **NO** ☐

HEPATITIS B

Have you received the **Hepatitis B** Vaccine series? **YES** ☐ **NO** ☐

If no, you must complete the Hepatitis B declination and waiver form.

If yes, what was the result of your **Hepatitis B** surface antibody test following the vaccine series?

POSITIVE ☐ **NEGATIVE** ☐

YALE NEW HAVEN HEALTH
MEDICAL STAFF REQUIREMENTS
IMMUNIZATIONS AND TB SURVEILLANCE

Based upon current standards of OSHA/AHA/CDC/Joint Commission and YNHHS policy, applicants to the Medical Staff and Clinical Fellows are required to submit their immunization/test records to Medical Staff Administration along with the application for appointment. For your convenience, a standardized reporting form is enclosed. The following documentation is required:

- **MEASLES** (for those whose DATE OF BIRTH is 1/1/57 or later), statement of history of illness is not acceptable: A statement of date of positive antibody titer
  Or
  Dates of Immunization with MMR vaccine (2 doses subsequent to first birthday)

- **RUBELLA** (for those whose DATE OF BIRTH is 1/1/57 or later), statement of history of illness is not acceptable: A statement of date of positive antibody titer
  Or
  Dates of Immunization with MMR vaccine (2 doses subsequent to first birthday)

- **MUMPS** (for those whose DATE OF BIRTH is 1/1/57 or later), statement of history of illness is not acceptable: A statement of date of positive antibody titer
  Or
  Dates of Immunization with MMR vaccine (2 doses subsequent to first birthday)

- **HEPATITIS B**
  A statement of date of positive hepatitis b surface antibody titer
  Or
  Date of completion of Immunization series
  Or
  Signed attached declination and waiver

- **VARICELLA-ZOSTER VIRUS**
  A statement of history of physician-diagnosed illness (chicken pox, shingles, or herpes-zoster)
  Or
  Dates of Immunization with Varivax (2 doses)
  Or
  Result of antibody titer.

- **TETANUS-DIPHTHERIA-PERTUSSIS**
  Date of immunization with Tdap since 2005

- **TB SKIN TEST**
  A negative 2-step PPD within the most recent 12 months
  Or
  For those with two years of serial PPD testing, a single baseline negative PPD within most recent 12 months
  Or
  A negative Interferon Gamma Release Assay (IGRA) result for TB within past 12 months

Or
For those with a positive PPD or positive IGRA, date of evaluation for Latent TB Infection (LTBI) and a chest radiograph report subsequent to positive PPD or positive IGRA.

Members of the Medical Staff with negative PPD or negative IGRA result will be required to document annual PPD or IGRA testing during the bi-annual re-credentialing process.

- **INFLUENZA**
  Vaccination required annually: evidenced by documentation from OHS, attestation by practitioner of vaccine receipt, or statement of declination for medical or religious reason.

- **COVID-19** statement of history of illness is not acceptable
  The brand and date(s) of vaccine and booster must be included on the immunization form
  And
  An image of vaccination card or documentation from electronic medical record must be provided, which includes the initial two doses of Moderna or Pfizer, or one dose of J&J, **and** a booster dose

Special Considerations for Lawrence and Memorial and Westerly Hospitals:

Medical Staff of Lawrence and Memorial and Westerly Hospitals ***not*** employed by NEMG are strongly recommended to receive influenza vaccine, but may decline the vaccine.

ADDITIONAL REQUIREMENTS

Medical Staff who care for patients in negative pressure isolation rooms are expected to complete fit testing for the N95 respirator on an annual basis. Medical Staff who interpret tests requiring color discernment (e.g. dipstick of urine) should have normal color vision. YNHHS Occupational Medicine and Wellness Services (OMWS) Clinics are available to carry out N95 fit testing and Ishihara color vision screening for Medical Staff members at no charge. OMWS Clinics also are available at no charge to Medical Staff members who require additional vaccine doses or serological testing for vaccine response. Medical Staff members may contact OMWS at the following numbers:

YNHH YSC: 203-688-2462 (1st floor, YNHH YSC East Pavilion)
YNHH SRC: 789-3721 (175 Sherman Avenue, 5th floor)
Bridgeport Hospital 203-384-3613 (226 Mill Hill Ave # 2)
Greenwich Hospital203-863-3400 (Watson Pavilion, 2nd floor)
L&M Hospital 860-442-0711, ext. 2289 (L&M Hospital)
Westerly Hospital 401-348-3783 (Westerly Hospital)

HEPATITIS B VACCINE DECLINATION

(Please sign if you are declining HepB vaccination):

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with
hepatitis B vaccine. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease.

_____
(Signature)

_____
Please print Full Name