

## YALE-NEW HAVEN HOSPITAL APPLICATION FOR RESIDENT OBSERVERS

Observer's Name: _____		
(Last Name)	(First Name)	(Middle Name)

Department : _____		
Section: _____	From: _____	To: _____
Purpose of Observation Visit: _____		

Medical School: _____	Degree: _____
Graduation Date: _____ MM/DD/YYYY	Foreign Medical Graduate <input type="checkbox"/> Yes <input type="checkbox"/> No
	ECFMG Issue Date: _____ MM/DD/YYYY

Internship, residency, fellowship training: <small>(Note clinical or research) <b>U.S. and Canadian appointments Only</b> Name of Training program (i.e. medicine, pediatrics, surgery, etc.)</small>	PGY Level	Hospital	Appointment Dates	
			From:	To:

**Attestation**

The individual listed above is requesting to visit Yale-New Haven Hospital (YNHH) strictly as an observer for the period of time 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 House Staff/Medical Staff while he/she is on YNHH premises.

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 YNHH or reading or writing in 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 and is not permitted to operate any equipment connected with the delivery of patient care.

The applicant:

- agrees to display appropriate identification while on YNHH premises
- agrees to complete the attached immunization testing record and fulfill documentation requirements as stipulated in the attached letter
- attests to having read the YNHH Policies and Procedures regarding Infection Control, Standard Precautions and Safety and Security
- agrees to sign and return "Medical Staff Guest and Observer Confidentiality Agreement"

Resident's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

YNHH Chief of Service Signature \_\_\_\_\_ Date: \_\_\_\_\_

YNHH Department Contact Person: _____	Contact Email: _____
Name of Current Department (not YNHH) _____	Hospital: _____
Dept. Telephone # _____	Dept. Fax # _____