17-9511 Observership Application Form

Number	36DAA82230	Maintainer	Allman, Chelsea A.
Type	Form	Publication Date	October 04, 2024
Applicability	Departmental		
Keywords	17 9511 Observership Application Form		

OBSERVER IDENTIFICATION DATA

Name (printed)_____ Date of birth:_____

Address:_____ Telephone Number: _____

City, State, Zip*:* _____ Email address:_____

Name of school, if applicable:_____

Date(s) Requested	Observation/Areas Requested

I understand that I must provide proof of personal insurance and understand I am responsible for any care provided as a result of any exposure. I understand that CAMC Health Systems will conduct a background check prior to the observation experience. I also must provide a negative drug screen within the past 6 months, evidence of either vaccination or immunity for MMR, and evidence of a negative TB skin test or a negative TB symptom survey. I understand that expenses for the checks and screens may entail a cost for which I might be billed. I certify I have no known physical or mental illness or condition including any contagious disease, which could be detrimental to the welfare or interfere with the care of any hospital patient or staff.

Observer signature:_____

Sponsor Contact Information

Department/Clinic Name:	Phone:
Sponsor Contact Person:	Phone:
Contact Information:	Phone: