UW Medicine
UNIVERSITY OF WASHINGTON
MEDICAL CENTER

UW Medical Center Observational Privileges request.

For MD observations, please submit completed application to observer@uw.edu

For RN or other patient care services staff member observations, please submit completed application to obsvrn@uw.edu

Answer all the questions below:

Observer's Name:	
Supervising Provider's Name:	
Department:	
Title:	Observer
End Date of Observational Activity:	

Allow three weeks for processing. Incomplete applications will not be accepted.

UWMC Medical Director/Chief Nursing Officer/Administrator Authorization:

Thomas Staiger, MD UWMC Medical Director	Thomas Hei, MD UWMC Associate Medical Director, Ambulatory Services	Cindy Sayre, PhD, RN Chief Nursing Officer	Jennifer Herrman Associate Administrator, Ambulatory Services	Date

Public Safety: When signed by the UWMC Medical Director/Chief Nursing Officer, this page acts as authorization for the person named above to receive an Observer badge. Do not issue a badge unless the UWMC Medical Director's/Chief Nursing Officer's signature is placed above.

Please note:

- You must have your UWMC photo ID issued by Public Safety, BB120, prior to observing at UW Medical Center.
- This process only grants you Observational Privileges at UW Medical Center.
- Incomplete packets will not be considered for approval.

Step 1: Biographical Information

Fill out the information below:

Your Name:

Your Email:

Your Address:

City, State:

Zip:

Are you 18 years of age or older? ◯ Yes ◯ No

Have you ever been convicted of a felony? ◯ Yes ◯ No

Have you ever had a medical license revoked or denied? ◯ Yes ◯ No

Read and sign below:

- *I understand the observational activity provided is done as a public service in the interest of medical education. I understand that the observational activity does not permit photography by the observer.*
- *I understand that all information about patients, whether it is medical or personal, is absolutely confidential. I have read and signed the attached confidential acknowledgment form.*
- *I understand that as an observer, regardless of background and training, I may not perform any medical procedures. I will not have direct contact with patients, nor have unsupervised access to patients.*
- *I agree to the following statements:*
  - *My required immunizations are current.*
  - *I have not had any exposure to measles, rubella, or chickenpox in the last 30 days.*
- *I agree to hold harmless the University of Washington and UW Medicine from any present and future liability and/or damages for injuries arising from or growing out of this observational experience.*

Applicant's Signature Date

If you are under 18 years of age, have your parents read and sign below:

Parental permission: *My daughter/son has permission to participate in a UW Medicine observational experience and I authorize UW Medicine to administer a Tuberculosis test as deemed necessary. I understand the above statements and verify the information is accurate and complete.*

Applicant's Parent's Signature Date

Step 2: Confidentiality Agreement

Read and sign below:

UW Medicine has a legal and ethical responsibility to safeguard the privacy of all patients and protect the confidentiality of their protected health information (PHI). Strong federal and state laws govern the privacy of our patients and their health information.

When you participate in an observational experience at UW Medicine, you are involved in a unique experience. You will be accompanying a healthcare professional for a specified period in a healthcare facility. During this time you will or may be seeing patients with a variety of medical issues and/or you may see, hear, or have access to confidential information relating to these patients. This relates to information past, present and future.

As a condition of participating in this observational experience, I understand and agree that:

- *I must maintain and safeguard the confidentiality of any and all UW Medicine protected health information.*
- *I will not access, use or disclose protected health information unless specifically approved as part of my observational experience. I will maintain all protected health information in the strictest confidence and will not disclose or allow access to protected health information to others.*
- *Any access to protected health information may be monitored to assure appropriate compliance with system integrity and UW Medicine policies and procedures.*
- *If I fail to comply with the above confidentiality guidelines, or if I breach patient confidentiality, this agreement will be terminated and my ability to participate in future activities at UW Medicine may be denied.*
- *I understand that it is my responsibility to protect patient information, confidential information, restricted information, and/or proprietary information even after end date of observational activity. It is unlawful to use or disclose UW Medicine patient information, confidential information, restricted information, and/or proprietary information for any unauthorized purpose.*

Applicant's Signature Date

Step 3: Supervision

Fill out the information below:

Who is supervising your observation?

What department or unit are they with?

What is their phone number?

What is their email?

What is the first day of your observational activity?

What is the last day of your observational activity?

Have the UWMC employee supervising your observation read and sign below:

I know this applicant and based on my knowledge of this applicant, his/her training, current competence, and health status as it affects performance, I attest that this person is physically and mentally competent to observe in the UW Medicine Clinics or other UW Medicine Areas, and is observing for the purpose of medical education, research, or training. I attest that the purpose of this is not solely for the benefit of a commercial vendor. I will introduce the visitor to patients. I also attest that I will receive the permission of the patient(s) for this person to observe.

UWMC Clinical Staff Sponsor **Date**

If you are observing more than one provider, fill in their names, departments, and emails below, and have them sign agreement to the above statement:

Name: Department: Email:

Additional UWMC Clinical Staff Sponsor Date

Name: Department: Email:

Additional UWMC Clinical Staff Sponsor Date

Step 4: Letter of Intent

Type a 100-250 word letter of intent explaining why you are interested in observing at UWMC and what you hope to gain from this experience.

Step 5: Immunization History

Gather documentation of your immunity to each item on the checklist below and attach it to this packet. Note that self-reported vaccine history is not acceptable as proof of immunity. Applications missing vaccine history will not be accepted.

Rubeola and Mumps - Record of two vaccines with first dose on/after age one and second dose at least 28 days after first dose OR positive IgG titers.

Rubella - Record of one dose of Rubella vaccine OR Positive IgG titer.

Varicella - Record of two vaccines with first dose on/after age one and second dose at least 28 days after first dose OR Positive IgG titer.

Tetanus, Diphtheria and Pertussis - Record of a single dose of Tdap vaccine AND a Td-containing vaccine (DTaP,DTP.TD,Tdap) within the last 10 years.

Influenza - Flu vaccine for the current season **required September 1st-April 30th.**

Tuberculosis - Record of one of the following within the last year: Negative TB Test, Negative IGRA, T-Spot or Quantiferon Gold Blood Test AND Negative TB Symptom Survey. If you have had a positive test in the past, you will be required to submit a negative chest x-ray taken within the last year.

Hepatitis B – Although your exposure risk to Hepatitis B as an observer at UWMC is extremely low, we recommend that you be vaccinated.
Please do **one** of the following:

- Provide proof of Hepatitis B Vaccine series
- Provide proof of positive Hepatitis B titer
- Review the latest CDC educational material on Hepatitis B and sign Hepatitis B Declination Form (both attached)

Step 6: Tuberculosis Symptom Survey

Date: _____

_____

Last Name First Name MI

(Please print or type)

Date of Birth: _____ EID # _____

If at any time during the year, you experience these symptoms, notify the Employee Health Center (206) 598-7971.

Do you have any of the following symptoms?	**Yes**	**No**
Productive cough lasting longer than two weeks	☐	☐
Hemoptysis (coughing up blood)	☐	☐
Recent unexplained weight loss	☐	☐
Night Sweats	☐	☐
Fever	☐	☐
Loss of appetite	☐	☐
Lethargy / Weakness	☐	☐

If you answered 'yes' to any of the above statements, please describe your symptoms further in the space below. When did the symptoms begin?

Have you sought treatment? If yes, what treatment have you received?

UW Medicine
UNIVERSITY OF WASHINGTON MEDICAL CENTER

Employee Health Center

Hepatitis B Vaccine Declination

I understand that the University of Washington Medical Center recommends I be vaccinated with the hepatitis B vaccine. I have been provided with and have had the opportunity to review the latest CDC educational material, "Vaccine Information Sheet Hepatitis B, 07/20/2016". Due to my limited occupational exposure to blood or other potentially infectious materials as an Observer, I am declining to obtain this vaccination. I understand that by declining this vaccine, I may be at risk of acquiring hepatitis B.

Please print clearly:

Last Name First Name Middle Initial

Signature Date Signed

VACCINE INFORMATION STATEMENT

Hepatitis B Vaccine

What You Need to Know

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

Hepatitis B is a serious disease that affects the liver. It is caused by the hepatitis B virus. Hepatitis B can cause mild illness lasting a few weeks, or it can lead to a serious, lifelong illness.

Hepatitis B virus infection can be either acute or chronic.

Acute hepatitis B virus infection is a short-term illness that occurs within the first 6 months after someone is exposed to the hepatitis B virus. This can lead to:

- fever, fatigue, loss of appetite, nausea, and/or vomiting
- jaundice (yellow skin or eyes, dark urine, clay-colored bowel movements)
- pain in muscles, joints, and stomach

Chronic hepatitis B virus infection is a long-term illness that occurs when the hepatitis B virus remains in a person's body. Most people who go on to develop chronic hepatitis B do not have symptoms, but it is still very serious and can lead to:

- liver damage (cirrhosis)
- liver cancer
- death

Chronically-infected people can spread hepatitis B virus to others, even if they do not feel or look sick themselves. Up to 1.4 million people in the United States may have chronic hepatitis B infection. About 90% of infants who get hepatitis B become chronically infected and about 1 out of 4 of them dies.

Hepatitis B is spread when blood, semen, or other body fluid infected with the Hepatitis B virus enters the body of a person who is not infected. People can become infected with the virus through:

- Birth (a baby whose mother is infected can be infected at or after birth)
- Sharing items such as razors or toothbrushes with an infected person
- Contact with the blood or open sores of an infected person
- Sex with an infected partner
- Sharing needles, syringes, or other drug-injection equipment
- Exposure to blood from needlesticks or other sharp instruments

Each year about 2,000 people in the United States die from hepatitis B-related liver disease.

Hepatitis B vaccine can prevent hepatitis B and its consequences, including liver cancer and cirrhosis.

2 Hepatitis B vaccine

Hepatitis B vaccine is made from parts of the hepatitis B virus. It cannot cause hepatitis B infection. The vaccine is usually given as 3 or 4 shots over a 6-month period.

Infants should get their first dose of hepatitis B vaccine at birth and will usually complete the series at 6 months of age.

All **children and adolescents** younger than 19 years of age who have not yet gotten the vaccine should also be vaccinated.

Hepatitis B vaccine is recommended for unvaccinated **adults** who are at risk for hepatitis B virus infection, including:

- People whose sex partners have hepatitis B
- Sexually active persons who are not in a long-term monogamous relationship
- Persons seeking evaluation or treatment for a sexually transmitted disease
- Men who have sexual contact with other men
- People who share needles, syringes, or other drug-injection equipment
- People who have household contact with someone infected with the hepatitis B virus
- Health care and public safety workers at risk for exposure to blood or body fluids
- Residents and staff of facilities for developmentally disabled persons
- Persons in correctional facilities
- Victims of sexual assault or abuse
- Travelers to regions with increased rates of hepatitis B
- People with chronic liver disease, kidney disease, HIV infection, or diabetes
- Anyone who wants to be protected from hepatitis B

There are no known risks to getting hepatitis B vaccine at the same time as other vaccines.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

3 Some people should not get this vaccine

Tell the person who is giving the vaccine:

- **If the person getting the vaccine has any severe, life-threatening allergies.**
  If you ever had a life-threatening allergic reaction after a dose of hepatitis B vaccine, or have a severe allergy to any part of this vaccine, you may be advised not to get vaccinated. Ask your health care provider if you want information about vaccine components.
- **If the person getting the vaccine is not feeling well.**
  If you have a mild illness, such as a cold, you can probably get the vaccine today. If you are moderately or severely ill, you should probably wait until you recover. Your doctor can advise you.

4 Risks of a vaccine reaction

With any medicine, including vaccines, there is a chance of side effects. These are usually mild and go away on their own, but serious reactions are also possible.

Most people who get hepatitis B vaccine do not have any problems with it.

Minor problems following hepatitis B vaccine include:
- soreness where the shot was given
- temperature of 99.9°F or higher

If these problems occur, they usually begin soon after the shot and last 1 or 2 days.

Your doctor can tell you more about these reactions.

Other problems that could happen after this vaccine:

- People sometimes faint after a medical procedure, including vaccination. Sitting or lying down for about 15 minutes can help prevent fainting and injuries caused by a fall. Tell your provider if you feel dizzy, or have vision changes or ringing in the ears.
- Some people get shoulder pain that can be more severe and longer-lasting than the more routine soreness that can follow injections. This happens very rarely.
- Any medication can cause a severe allergic reaction. Such reactions from a vaccine are very rare, estimated at about 1 in a million doses, and would happen within a few minutes to a few hours after the vaccination.

As with any medicine, there is a very remote chance of a vaccine causing a serious injury or death.

The safety of vaccines is always being monitored. For more information, visit: **www.cdc.gov/vaccinesafety/**

5 What if there is a serious problem?

What should I look for?

- Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or unusual behavior.

  Signs of a **severe allergic reaction** can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would start a few minutes to a few hours after the vaccination.

What should I do?

- If you think it is a **severe allergic reaction** or other emergency that can't wait, call 9-1-1 or get to the nearest hospital. Otherwise, call your clinic.

  Afterward, the reaction should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor should file this report, or you can do it yourself through the VAERS web site at **www.vaers.hhs.gov**, or by calling **1-800-822-7967**.

VAERS does not give medical advice.

6 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines.

Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling **1-800-338-2382** or visiting the VICP website at **www.hrsa.gov/vaccinecompensation**. There is a time limit to file a claim for compensation.

7 How can I learn more?

- Ask your healthcare provider. He or she can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636** (**1-800-CDC-INFO**) or
  - Visit CDC's website at **www.cdc.gov/vaccines**

Vaccine Information Statement

Hepatitis B Vaccine

7/20/2016

42 U.S.C. § 300aa-26

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