2023 Society of Clinical Surgery
OR Observation Requirements

Documentation Checklist

1) **Short Term Observer Packet –** upload to Dropbox
   - ☐ Observation Agreement (pg. 2)
   - ☐ Observation Application (pg. 3)
   - ☐ Confidentiality Agreement (pg. 5)
   - ☐ Vaccination History (pg. 6)
     - TB Test to be completed within 3 months of observation date (other packet materials can be submitted before then)
   - ☐ COVID Documentation (pg. 7)
   - ☐ POI Form (pg. 8-9)
2) **Copy of Government Issued ID –** upload to Dropbox
3) **HireRight Background Check** (you will be sent an email after the observer packet and TB Test have been submitted)

Submission Deadlines

March 15th: Can begin submitting documentation through Dropbox link

August 9th: Can begin submitting TB Test documentation

October 1st: Deadline for packet submissions

October 16th: Final date for all documents listed above to be submitted

If you have any questions or issues, please contact scsboston2023@bwh.harvard.edu

BRIGHAM HEALTH
BWH BRIGHAM AND WOMEN'S HOSPITAL

Clinical Observation Experience Policy & Agreement

CLINICAL OBSERVERS ARE NOT ELIGIBLE FOR CLINICAL PRIVILEGES

- The observer may join rounds but cannot ask questions or interrupt workflow. If there is time after rounds, questions can be directed to the senior resident.
- The observer can introduce themselves to a patient, but in no way can participate in the care of the patient, the documentation of the care, or give even the appearance of being a caregiver. In particular, the observer may not ask questions, take history, or touch or examine the patient.
- The observer should not interact with ancillary staff and should never be a transmitter of medical information.
- The observer should not interact with family members of the patient.
- The observer should not attend family meetings.
- The observer should not be confused with students, who are participating in a formal training program or under a formal affiliation agreement.
- The observers' activities must not interfere with the education or activities of medical students or graduate medical education trainees.
- The observers are not hospital employees or members for the professional staff and may not represent themselves as such.
- Observers are not allowed to place medical orders, provide verbal orders, or convey medical recommendations to other patients or other healthcare members
- Observers cannot participate in research activities
- Observers cannot publish any works that imply a formal affiliation with BWH
- Observers cannot suggest or imply that they are acting with authority of BWH

If an observer is unable to adhere to these guidelines, BWH reserves the right to terminate the observational experience.

_____ _____

Clinical Observer's Signature Date

_____

Clinical Obserer's Name

_____ _____

Faculty Supervisor Signature Contact Phone Number

Clinical Observership Experience Application
BRIGHAM AND WOMEN'S HOSPITAL

This application must be completed for individuals who would like to observe patient care at Brigham and Women's Hospital. For medical students from other institutions who are interested in participating in the care of patients or seek to receive clerkship credit for this experience, please contact the HMS Registrar's Office at *exchangeclerkship@hms.harvard.edu* for more information regarding elective clerkship rotations. For residents and fellows from other institutions who are interested in participating in the care of patients, please contact the Graduate Medical Education office for more information regarding elective rotations. Please submit this application and all required supporting documentation (see checklist) to BWH Office of Sponsored Staff.

Section 1 - To be completed by visiting scholar:

First Name _____ Last Name _____

Date of Birth _____ Gender _____ Social Security Number _____ Ethnicity _____

Home Address _____

State/Country/Zip Code _____ Email _____

Phone Number _____ US Citizen Y/N

I _____ ("Clinical Observer") understand that this observational experience is being made available to me based upon BWH's interest in training future health care professionals. I understand that this experience is solely for my educational benefit and that my status is that of an observer. I understand and acknowledge that I do not have an employment or volunteer relationship with BWH/HMS and that I will not be providing any services to BWH/HMS during the course of my observational experience.

Clinical Observer's Signature: _____ Date: _____

Section 2 - To be completed by BWH Department:

BWH Contact Person/Program Coordinator: Caroline Qualls Phone number: 617-732-8181

BWH Faculty Supervisor: Dr. C. Keith Ozaki Phone number: 617-732-8181

The above-named Clinical Observer would like to apply for an observational experience in the BWH Department of

Surgery in General Surgery (division or program), for the period

from 11/10/2023 to 11/10/2023 at (hospital) BWH (location/ward) Operating Rooms % _____

from _____ to _____ at (hospital) _____ (location/ward) _____ % _____

Educational goals of the proposed observership: Society of Clinical Surgery Annual Event

BWH Signatures:

Faculty Supervisor: _____ Date: _____

Dept Chair/Assoc Chief Nurse Officer or Designee _____ Date: _____

PARTNERS HEALTHCARE

PARTNERS HEALTHCARE SYSTEM
PARTNERS COMMUNITY HEALTHCARE

CONFIDENTIALITY AGREEMENT

Partners HealthCare System, its affiliates and joint venturers, and Partners Community HealthCare have a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their health information. Additionally, Partners HealthCare System, its affiliates and joint venturers, and Partners Community HealthCare must assure the confidentiality of its employee, payroll, fiscal, research, computer systems, and management information. In the course of my employment/assignment at a Partners organization/practice, I may come into the possession of confidential information. In addition, my personal access code [User ID and Password] used to access computer systems is also an integral aspect of this confidential information.

By signing this document I understand the following:

1. Access to confidential information without a patient care/business need-to-know in order to perform my job---whether or not that information is inappropriately shared---is a violation of this policy. I agree not to disclose confidential or proprietary patient care and/or business information to outsiders (including family or friends) or to other employees who do not have a need-to-know.
2. I agree not to discuss confidential patient, employee, payroll, fiscal, research or administrative information where others can overhear the conversation, e.g., in hallways, on elevators, in the cafeterias, on the shuttle buses, on public transportation, at restaurants, at social events. It is not acceptable to discuss clinical information in public areas even if a patient's name is not used. This can raise doubts with patients and visitors about our respect for their privacy.
3. I agree not to make inquiries for other personnel who do not have proper authority.
4. I know that I am responsible for information that is accessed with my password. I am responsible for every action that is made while using that password. Thus, I agree not to willingly inform another person of my computer password or knowingly use another person's computer password instead of my own.
5. I agree not to make any unauthorized transmissions, inquiries, modifications, or purgings of data in the system. Such unauthorized transmissions include, but are not limited to, removing and/or transferring data from Partner's computer systems to unauthorized locations, e.g., home.
6. I agree to log off a Partners workstation prior to leaving it unattended. I know that if I do not log off a computer and someone else accesses confidential information while the computer is logged on with my password, I am responsible for the information that is accessed.

Partners HealthCare System, its affiliates and joint venturers, and Partners Community HealthCare have the ability to track and monitor access to on-line records and reserves the right to do so. Partners HealthCare System, its affiliates and joint venturers, and Partners Community HealthCare can verify that those who accessed records did so appropriately.

I have read the above special agreement and agree to make only authorized entries for inquiry and changes into the system and to keep all information described above confidential. I understand that violation of this agreement may result in corrective action, up to and including termination of employment and/or suspension and loss of privileges. I understand that in order for any User ID and/or Password to be issued to me, this form must be completed.

_____ _____

Signature of Employee / Physician / Student / Volunteer / Non-Partners Personnel Date

_____

Print Name

83268 01/17/06

To Be Filed in Employee's Personnel Record

Mass General Brigham

Health Screening Requirements

Observer Name:_____ **Date of Birth:**_____

Must be Completed by Personal Health Care Provider or School Health Office:

All personnel who will work, volunteer, or observe at a Mass General Brigham healthcare facility are required to meet the minimal infection control standards on page 1.

Tuberculosis (TB):

BAMT within 3 mos. of screening date	QFT Date: _____ Result: _____	OR	T-Spot Date: _____ Result: _____	
For history of +TST or +BAMT a Chest X-Ray (CXR) is required	CXR Date: _____		Chest X-Ray Result_____	
LTBI TX	Dated of Completion: _____	OR	LTBI TX Not Completed_____	
Symptom Review *(Only for applicants who have a history of a positive PPD)*	Loss of appetite ❒ Yes ❒ No Unexplained weight loss ❒ Yes ❒ No Night Sweats ❒ Yes ❒ No		Fever ❒ Yes ❒ No Fatigue ❒ Yes ❒ No Productive Cough ❒ Yes ❒ No	

TB SCREENING:
Have you lived for more than one month in a country with a high rate of TB? (Any country other than the United States, Canada, Australia, New Zealand, and those in Northern Europe or Western Europe) YES _____ NO _____
Are you immunosuppressed? YES _____NO _____
Have you had close contact with someone who had infectious TB disease since your last TB screening? YES____ NO ____

Other Requirements

		Date		Date	Titer Result (circle)	Date
MMR	MMR #1	_____	MMR #2	_____		
Measles	Measles #1	_____	Measles #2	_____	POS / NEG	_____
Mumps	Mumps #1	_____	Mumps #2	_____	POS / NEG	_____
Rubella	Rubella #1	_____			POS / NEG	_____
Hx of Varicella	Yes___		No____			
Varicella	Varicella #1	_____	Varicella #2	_____	POS / NEG	_____
COVID 19	COVID 19 #1	_____	COVID19 #2	_____	Booster:	_____
	Manufacturer:	_____	Manufacturer:	_____	Manufacturer:	_____
Influenza (Seasonal)	Influenza	_____				

Provider Name (Print): _____ **Phone:** _____

Provider Signature: _____ **Date** _____

BRIGHAM AND WOMEN'S HOSPITAL

OCCUPATIONAL HEALTH SERVICES
75 Francis Street
Boston, MA 02115
Neville House Clinic tel. 617-732-6034
fax 1.617. 975-0808

Last Name _____ First Name _____ Date of Birth _____

COVID Documentation

Vaccine	Product Name/Manufacturer and Lot Number	Date	Healthcare Professional or Clinic Site
1st Dose COVID-19		____/____/____ mm dd yy	
2nd Dose COVID-19		____/____/____ mm dd yy	
Other		____/____/____ mm dd yy	
Other		____/____/____ mm dd yy	

Print Name Health Care Provider _____ Signature _____ Date _____

Location _____ Telephone _____

RESET

Brigham and Women's Hospital
Founding Member, Mass General Brigham

POI FORM

Department Details

Department Surgery Division General & GI Surgery BR# 0192

Start Date 11/10/2023 End Date: 11/10/2023

POI Role Observer

Principal Investigator Name Dr. C. Keith Ozaki

Principal Investigator Email: ckozaki1@bwh.harvard.edu

Personal Information

First Name | Middle | Last Name

Date of Birth (mm/dd/yyyy) | Gender | Social Security Number | Ethnicity

Address | City

State/Country | Zip | Phone

Email Address

Emergency Contact Name | Emergency Contact Phone

Work Related License Information

(select one)

License Type | License Number | Expiration Date

Issuing Agency | (select one) Issuing State

Employment Eligibility

US Citizen (select one) If no, authorized to Work in the U.S.? (select one) Work Visa/Authorization Type (select one)

Work Authorizing Document # Expiration Date:

Position Details

Is the POI being compensated? No If yes, pay source _____

Will the POI be practicing medicine and/or assuming clinical duties?	○ Yes	◉ No
Will the POI have contact with children?	○ Yes	◉ No
Will the POI have contact with human bodily fluids?	○ Yes	◉ No
Will the POI engage in human subject research?	○ Yes	◉ No
Will the POI engage in federally funded research?	○ Yes	◉ No
Has the POI traveled outside the U.S. in the past 30 days?	○ Yes	○ No

If yes, where? _____

Is the POI in a Degree Program?	○ Yes	◉ No
Will the POI be working remotely?	○ Yes	◉ No

External Institution (select one)

External Other Society of Clinical Surgery

Work Schedule (hours per day & days of the week) Friday 11/10/23, 5 hours

Access to MGB Network Needed? No Email Account Needed? No

Primary Work Location: BWH

Duties/Responsibilities:

Observing OR Cases during the morning of 11/10/2023 as part of the Society of Clinical Surgery Annual Meeting, hosted by the BWH Department of Surgery

Years of Research Experience: (select one)

Does POI already have a MD?	◉ Yes	○ No
Does POI already have a PhD?	○ Yes	○ No

If POI is in a degree-granting program, indicate which type (high school, undergraduate/college, master's program, PhD program, medical school)	○ Yes	◉ No
If POI is in a degree-granting program, is their work at BWH directly related to the completion of their degree program?	○ Yes	◉ No
Has the candidate worked in any capacity at BWH before? If yes, explain where	○ Yes	○ No