Northwestern Medicine®

Date: _____
Host Department: _____
Host contact: _____
Requested dates on site: _____

Multi-Day Only: NON-EMPLOYEE HEALTH REVIEW FORM

Welcome to Northwestern Medicine! Prior to starting in your observation with us, you must complete all the items listed on the checklist below and receive clearance from Occupational Health. Failure to complete this form or provide the necessary documentation may delay your observation start date. This form applies to Observers who will be on-site at any Northwestern Memorial HealthCare (NMHC) facility longer than one day.

1. COMPLETE THE PERSONAL INFORMATION SECTION

FULL NAME:	DATE OF BIRTH:	LAST 4 DIGITS OF SS#:
HOME ADDRESS:	CITY/STATE:	ZIP CODE:
HOME PHONE:	CELL PHONE:	
EMAIL:	EMERGENCY CONTACT:	EMERGENCY CONTACT PHONE:
NM OBSERVER HOST INFORMATION: NM Host Name: NM Host Phone/Email: NM Host Department:		
Do you have any physical limitations or disabilities which would impact your ability to perform your function or assignment? If so, please describe:		
Do you have any medical conditions that should be known in order to provide safety for you while you perform your function/assignment to our healthcare organization and our patients?		

2. PREPARE COPIES OF YOUR HEALTH/IMMUNIZATION/BLOOD TITER RECORDS

If you do not have any or all of these health records in your possession, you may be able to get copies from your doctor, your school (if you are a current or recent student), or a current/recent employer. If you are missing any or all of these records from these sources, you will still need to obtain and provide the documentation for these items. You may be able to complete these tests at your doctor's office or a local convenient care health center. However, you will be responsible for the cost of these tests if not covered by an applicable health insurance plan you may have.

☐ COVID-19 VACCINATION (Provide proof of fully vaccinated – i.e. Two weeks following final dose)

☐ MEASLES/MUMPS/RUBELLA (MMR) IMMUNITY- This requirement can be satisfied one of two ways:

- Provide proof of completing the MMR vaccine series (which consists of two doses), OR
- Provide blood test results showing immunity to measles/rubeola, mumps, and rubella

☐ VARICELLA (CHICKENPOX) IMMUNITY- this requirement can be satisfied one of two ways:

- Provide proof of completing the varicella vaccine series (which consists of two doses), OR

- Provide blood tests results showing immunity to varicella
- Please note: Having had chicken pox in the past does NOT constitute proof of immunity

☐ TETANUS, DIPHTHERIA, PERTUSSIS (TDAP)

- Required for individuals coming into direct contact with NM patients.
- Provide proof of vaccination as an adult (over 11 years)
- Please note: The vaccine must include pertussis. Td vaccine, which is without pertussis, does not fulfill the requirement

☐ SEASONAL INFLUENZA (FLU) VACCINATION- this is a requirement from Sept 1- May 1:

- Our mandatory flu program requires you to obtain the flu vaccine during the current flu season. If previously vaccinated for this year's flu season, please provide documentation of receiving the influenza vaccine.

☐ RESULTS OF TUBERCULOSIS TEST(S)- this requirement can be satisfied one of three ways:

- Provide the documentation of two negative TB skin tests, also called PPDs (one no more than 1 year old, and one no more than 90 days prior to your start date), OR
- Provide the documentation of one negative TB blood test (we'll accept Quantiferon Gold or T-spot) performed within the last 90 days.
- If you've had a positive TB test, provide the report of a normal chest x-ray performed within the past year. The chest x-ray should post date your positive TB test.

☐ HEPATITIS B: Hepatitis B is not required but highly recommended if your role will be in a direct patient care area. If you do have this documentation, please provide proof of immunity which would be either official documentation of the 3 series of immunizations or a positive titer for Hepatitis B.

3. PLEASE EMAIL COMPLETED FORM (INCLUDING YOUR HEALTH/IMMUNIZATION RECORDS) TO THE FOLLOWING OFFICE FOR CLEARANCE:

Downtown Location	West Region	North and Northwest Region
• Northwestern Memorial Healthcare (NMHC) • Northwestern Memorial Hospital (NMH) • Northwestern Medical Group (NMG)	• Central DuPage Hospital (CDH) • Delnor Hospital • Marianjoy Rehab Hospital • Kishwaukee Hospital • Valley West Hospital • Regional Medical Group-West	• Lake Forest Hospital (LFH) • McHenry Hospital • Huntley Hospital • Woodstock Hospital • RMG- Northwest
Email: NMPGCH@nm.org Fax: 312-926-1787	Email: NMOccHealth@nm.org Fax: 630-933-5289	Email: OccHealthNWR@nm.org Fax: 815-363-0136

All records should be faxed at the same time. Please do not fax until you have accumulated all of your required records. In addition, immunization records will not be accepted without this form. If records are being sent directly from your doctor's office, please make sure they have a copy of this form.

SIGNATURE:_____ DATE:_____

☐ Cleared to be onsite from Occupational Health

OCC HEALTH REPRESENTATIVE:_____ DATE:_____

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Single and Multi-Day Observation: Daily Symptom Screening Questionnaire

Name: _____ **Birth Date:** _____

Screening Questions

For your safety, we are screening all patients/visitors entering a Northwestern Medicine facility. Please review each of the following questions and answer in the box below whether both answers are NO or if either answer is YES.

1. **Are you currently experiencing any of the following symptoms?**

   - Fever greater than 100°F
   - Cough
   - Chills
   - Shortness of breath
   - Muscle pain or body aches not related to physical activity
   - New headache
   - Sore throat
   - New nasal congestion or runny nose
   - More than one episode of Vomiting or diarrhea
   - New loss of taste or smell

2. **Have you have been diagnosed with a COVID-19 infection in the past 20 days?**

Please indicate whether all of the above answers are **NO**. If any of the questions are yes, please indicate **YES** in the box below:

☐ YES ☐ NO

Please Note: Individuals participating must be fully vaccinated for COVID-19 (2 weeks post final dose administered) to be eligible for a single or multi day observation.

Observer Signature_____
Date _____

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Application for Clinical Observation at Northwestern Medicine

Please type or print all information clearly.

Name:_____

Affiliation:_____

Position (Check One):

☐ Attending Physician
☐ Researcher
☐ Resident/Fellow
☐ Licensed Allied Health Prof.
☐ Medical Student
☐ Other (specify)_____

Reason for Observation:

☐ Medical/Professional Education
☐ Other_____

Requested Dates for Observation:

Start Date: _____ End Date: _____

Clinical Areas to be observed:

☐ Physician Office: _____
(Please specify)

☐ Diagnostics: _____
(Please specify)

☐ Emergency Department

☐ Inpatient: _____
(Please specify)

☐ Operating Room/Procedural Area:

Case Type _____

Specific Case _____

Case Date _____

Confirmation of COVID-19 Fully Vaccinated: ☐ Yes, Fully Vaccinated for COVID-19

By signing this form below, I agree to abide by all NM regulations, requirements, policies, and procedures.

_____ _____
Applicant Signature Date

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For Educational Observations Only - APPROVED BY:

_____ _____
Department Chair or Chief Date

_____ _____
NMH Medical Director of Area to be Observed Date

_____ _____
Host (Physician or NMH Director) Date

_____ _____
Central Campus: Director, Academic Affairs, NMHC Date
All other regions: CMO/CNE* per visiting site
**Can designate a delegate to approve*

For observation in the OR, below signature is also required and Observer must be 18+

_____ _____
Director, Surgical Services Date

For Career Planning/Guidance Observations Only - APPROVED BY:

_____ _____
Hospital based Observation – Hospital CMO/CNE*
**Can designate a delegate to approve*
Physician Office based Observation – RMG/NMG CMO Date

For Recruitment Observations Only - APPROVED BY:

_____ _____
NM Hiring Manager Date

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CLINICAL OBSERVER
CONFIDENTIALITY AND NON-DISCLOSURE AGREEMENT

This Agreement is made and entered into this _____ day of _____, by and between Northwestern Memorial HealthCare (its subsidiaries and affiliated corporations) (together, "NMHC") and _____("Clinical Observer").

The Clinical Observer has requested access to observe NMHC's operations which may involve and expose certain Confidential Information, as defined below.

Accordingly, as a condition of and in consideration of my status as a Clinical Observer, I acknowledge and agree to the following:

1. I acknowledge and agree that in the course of, or incident to, observing operations at NMHC, NMHC may provide access to, or I will otherwise become exposed to Confidential Information. The term "Confidential Information" shall include (a) all information that concerns the business or affairs of NMHC including, without limitation, financial information, business plans, design and construction plans, medical records and other patient, hospital and physician data, know-how, operational information and techniques, and computer software, data, coding systems and documentation licensed to NMHC or owned by NMHC; (b) patient information, including, but not limited to name, address, diagnosis, medical history, discussions with physician, medication, names of family members, diagnostic test results and other medical record content and (c) any other information reasonably identified by NMHC as confidential.

2. I agree to hold the Confidential Information in the strictest confidence, and will exercise at least the same care with respect thereto as I exercise with my own confidential or proprietary information, and will not, without the consent of the owner of the Confidential Information, divulge, copy, release, sell, loan, review, alter or destroy any Confidential Information. Furthermore, I understand that patient privacy and confidentiality is protected from disclosure under state and federal law and I agree to abide by such law and NMHC's Privacy and Confidentiality Policy (NMHC ADM 01.0015).

3. I understand that photography, videography, or audio recording, including with cell phones, during an observation is strictly forbidden except for prior arrangements with Media and then only with the express written authorization of the patient and NMHC support.

4. I may be required to utilize computer systems as part of my Observation. If applicable, I understand that the ID number and passwords issued to me will be a unique code that identifies me for the computer systems. All inquiries and entries that I make will reference my identity and I will be fully responsible for them. Accordingly, I will maintain the confidentiality of my ID number and passwords and not reveal them to others. If at any time I feel the confidentiality of my ID number or passwords has been broken, I will contact my principal contact immediately and request a new ID number and passwords. I further understand that any information I access from the computer systems is strictly confidential and to be used only in the performance of my necessary duties.

5. This Agreement shall be governed by, and construed in accordance with, the substantive laws of the State of Illinois.

6.

Signature page to follow

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7. I agree to waive and release any and all rights and claims for damages that I may have against NMHC, its representatives, employees and medical staff, as a result of my participation as a Clinical Observer. In the event of an injury, I voluntarily assume responsibility for any medical treatment.

8. This Agreement constitutes the entire Agreement between the parties hereto with respect to the subject matter of this Agreement.

I have read and agree to abide by the Privacy and Confidentiality Policy (https://nm.ellucid.com/documents/view/4019) regarding the importance of maintaining security, privacy and confidentiality of all protected health information, information related to business operations, and other sensitive information. Intentional, accidental, or involuntary violation of confidentiality through verbal, written or electronic communications will result in investigation. I understand that non-compliance with this policy may result in corrective action, including immediate termination from the premises, as determined to be appropriate. I agree to cooperate with any investigation regarding possible privacy breaches. Any violation of confidentiality may result in legal action.

Printed Name: _____

Signature: _____

Date: _____