



INDIVIDUAL AGREEMENT
Observational Visitor Experience

Dear _____,

We are pleased that you have chosen Stanford Health Care (SHC) for your observation experience. We believe in sharing our knowledge and expertise with our colleagues and hope that your visit with us will be rewarding.

Your Observation Visit is scheduled for: (Date) _____.
Your Visit Coordinator: (Name, Title) _____ and
Unit/Department _____ have agreed to supervise your observational experience.

Please contact the Visit Coordinator at (Phone number) _____ to schedule a meeting.

Please read the following terms and conditions of your observation. Please initial and sign as indicated, and return **two** copies to:

Stanford Health Care
Center for Education and Professional Development
300 Pasteur Drive, MC 5534
Palo Alto, CA 94305-5534

Please note we will need copies of the health documentation requirements prior to you starting a patient care observational experience.

If you have any questions or need assistance with addressing our terms and conditions, please feel free to call me.

Sincerely,

[Manager/Director/Designee Name]
[Title]
[Department]
[Contact Information]

I understand that SHC has the right to immediately and without prior notice terminate my participation in this program for failure to abide by SHC rules, regulations and policies, or for any other reason deemed adequate by SHC. **Visitor initial** _____

I understand that I must provide documentation for the following SHC health requirements before I can start my observational visit:

1. A PPD (Tuberculin Skin Test) or **Quantaferon** test within the previous 12 months of the start of your SHC observational experience.
 - a. **If the test is newly positive**, a new chest X-ray is required before commencing with the observational experience.
 - b. **If the test is known to be positive**, a chest X-ray is required within the previous **three** months of the start date of the observational experience at SHC.
2. Documentation of immunity to measles, rubella, chickenpox/varicella, Tetanus, Diphtheria, Pertussis and mumps. These may be provided two ways:
 - a. Documentation of appropriate number of doses of the vaccines.
 - b. Laboratory reports of positive titers for each of these diseases.
3. Hepatitis B vaccine x 3 doses or a positive titer.
4. Documentation of influenza vaccination if the experience occurs from November 1st through March 31st.

(Please attach documentation) **Visitor initial**_____

I understand that I must complete the following activities before I can start my observation:

1. Provide a list of specific learning objectives for this observation
2. Sign Visiting Observer Attestation Agreement (enclosed)
3. Complete Visiting Observer HIPAA Guide (enclosed)
4. Sign the SHC Code of Conduct (enclosed)
5. Sign Visiting Professional Agreement (enclosed)

(Please attach documentation) **Visitor initial** _____

All medical record information is private and must be kept confidential. I understand that for unauthorized access or disclosure of information, my experience is immediately terminated, and there are also civil penalties which can be imposed for each disclosure. Psychiatric records, alcohol or substance abuse treatment records, genetic test records, and HIV tests are afforded greater legal protection.

Visitor acknowledges and agrees that in the course of any activities carried out in connection with the Program, the visitor shall not (i) have any contact with or provide medical services to SHC patients or (ii) have access to any Protected Health Information as such term is defined in 45 CFR §164.501.

Visitor shall carry his/her own insurance that covers such liabilities, in the form and amount required under California law. Visitor shall be responsible for filing and defending his or her worker's compensation claims. Visitor shall indemnify and hold harmless SHC against any costs, expenses or damages incurred by SHC as a result of a workers' compensation claim.

Visitor initial _____

