ADULT REQUEST FOR OBSERVATION EXPERIENCE
INCLUDING PATIENT ROOMS

_____
(Date)

_____, (Please Print Observer's Full Name)

You have requested the opportunity to observe our operations on _____ (Unit) during the

_____ (shift time) on _____ (date). In order for Lima Memorial

Health System to provide for this observation period, you agree to:

- Hold LMHS harmless and indemnify LMHS for any personal injury you incur during this period of observation.
- Assume responsibility for your conduct and attendance.
- Assume responsibility for confidentiality of information you may become aware of during the observation period. It is of utmost importance that you understand that any information you are exposed to in the LMHS setting in regards to patients must not be shared with anyone in the community. You will indemnify LMHS for any loss in this regard.
- Assure that, to the best of your knowledge, you have not been exposed to any communicable diseases such as chickenpox, measles, etc. within the last three (3) weeks.

During your observation period, you will have a designated Associate of Lima Memorial Health System that you will be observing. You are to follow the directions of that Associate at all times. You are to wear the same protective garb as your designated Associate when entering patient's rooms. You are not permitted to enter the rooms of any patients in isolation or any patient room that your designated Associate feels would not be appropriate. You are not permitted to give any patient care or have direct hands-on contact with patients during your observation period. In the event of a fire alarm (Code Red) or disaster (Condition Yellow or Green), please stay with your designated Associate and follow their direction, unless you are otherwise instructed.

At the time you report for observation experience, you must show proof that you have had a negative TB test within the past year. Attire for the day, will be required to follow LMHS Dress Code policy.

Thank you for your interest,

_____ _____
Observers Signature Date

_____ _____
LMHS Representative Signature Date

*****Return form and badge to HR after Job Shadow completed.**