OBSERVER PROCESSING CHECKLIST

Please print and complete this document to move forward with your on-boarding process.

1. Observer Orientation Packet:

   In this document you will have the following forms. Make sure to complete these forms and have them ready to submit to Medical Staff Specialist:

   a. Observer Orientation Checklist

   b. Observation Form

   c. Request for Medical Observation Status (Sponsoring Physician)

   d. HIPAA & Patient Privacy Quiz

   e. UMC Privacy & Security Practices

   f. Confidentiality Agreement

   g. Fair Employment Law Review Acknowledgment

   h. Operating Room Orientation for Observers (must be over 18)

   i. Instructions for the UMC Website-On-Line Associate Orientation Presentation

   j. Background Check Consent Form

   k. Visiting Observer Authorization Form

   l. Consent and Statement of Applicant for Observation

2. View the On-Line Associate's Orientation Presentation, and fill out the Observer Orientation Checklist. By signing this document, you acknowledge that you have completed the orientation and that you are responsible for the content. Please Print Out the UMC Associate's Online Orientation Program Certificate at the completion of your training. (Note: You must print or save certificate at time of completion, because you will not be able to re-access the certificate if you leave the screen.)

3. Please submit all items listed above to Evelia.Olivero@umcsn.com.

THANK YOU FOR CHOOSING UMC
WE ARE GRATEFUL AND EXCITED TO HAVE YOU ON OUR TEAM!

Observer Orientation Checklist

Please print and sign this checklist after you have completed the online Associates Orientation Presentation:

Print Name: _____ Program: _____

Are you a current UMC Employee? Yes ☐ No ☐

Check one of the following:

- ☐ Healthcare Provider
- ☐ Physician
- ☐ Student Observer
- ☐ Visiting Observer
- ☐ Other: _____

Information Covered:

Policies and Procedures-Code of Ethics, Patients Relations, Dress Code, Health Care Advanced Directives, Exposure Prevention and Exposure Protocol, Abuse policies, other policies that may apply.

Mandatory Education:

Please refer to 17 page for instructions and print certificate to be provided to Medical Staff Services.

HIPAA	Emergency Management and Emergency Preparedness
Corporate Compliance	Fire/Electric Power Safety
Confidentiality A greement	Exposure Protocol/Blood Borne Pathogens
Diversity, Communication and Teambuilding	Infection Prevention/Special Isolations
Fair Employment Law Review	General Safety and Hazardous Materials
Stroke Signs and Symptoms	Nation Patient Safety Goals

This is to verify that I have been trained and/or received training materials on the topics listed above. I am also responsible for the training and the materials discussed and/or handed out by UMC during this training.

Signature: _____ Date: _____

UMC
UNIVERSITY MEDICAL CENTER

Medical Staff Services
Observation Form

Observer Name:		Address:	
Hospital Department:		Telephone Number:	
Date of Birth:		SS#:	
Sponsoring Physician Name:		Email Address:	

As an Observer:

Agree	Don't Agree	
☐	☐	I agree to follow Hospital Health Insurance Portability and Accountability Act (HIPPA) Policies and Procedures.
☐	☐	I agree to comply with all federal, state and local laws and/or regulations relative to my activities at hospital.
☐	☐	I understand that my Observer Identification badge must be worn at all times and be clearly visible. Badges may not be worn backwards and should be displayed at chest level or higher. Badges will be returned to the Medical Staff Services Office when observation is completed. If badge is not returned, observer will not be able to reapply for future observation.
☐	☐	I acknowledge that I will not be an employee of the Hospital while engaging as an Observer at UMC and that I am ineligible to receive any benefits from the Hospital including, but not limited to, industrial insurance coverage.
☐	☐	I understand that I am responsible for any and all costs that pertain to required documents to observe at the Hospital.

Requirements: Observers

	Two-Step TB Skin Test/CXR		Fair Employment Law Review Acknowledgment
	Influenza Vaccination		Operating Room Orientation for Non-Physician Observers
	Immunization Record		Operating Room Orientation for Observers (if required)
	Observer Orientation Checklist		On-Line Associate Orientation Presentation Certificate
	Observation Form		Current CV/Resume
	Request for Medical Observation Status (Sponsoring Physician)		Government Issued Picture ID, Driver's License or Passport
	HIPAA & Patient Privacy Quiz		Current Medical License (Foreign Physicians must provide a copy of a License and/or Diploma) — For Physician Observers
	UMC Privacy and Security Practices		Background Screening Consent Form
	Confidentiality Agreement		Recommendation Letter from Principal or Counselor (Student only)
			Visiting Observer Authorization Form (Visiting Observer Only)

Requirement: Medical Staff Office

	$60.00 Fee for Observers and $40.00 Deposit for Badge		ECFMG Check (Foreign Physicians only)
	Verification of License (if applicable)		Background Check
	NPDB (if applicable)		Notification to Departments within 24 hours
	OIG (if applicable)		Verification of Departmental Orientation (if applicable)
	DEA (if applicable)		Attest to not being a foreign student
	State Pharmacy (if applicable)		Consent and Statement of Applicant for Observation

I am solely responsible for any and all injuries that I may experience while I am on the hospital premises. I release and hold University Medical Center, it's employees and agents harmless from and against any and all liability, losses, claims, or causes of action, and expenses connected therewith (including medical fees, court costs, and attorney's fees) caused or asserted to have been caused directly or indirectly, buy or during the time I am in the Hospital, and from any illness or untoward condition that I might encounter while observing delivery of patient care on the hospital premises.

I acknowledge that by virtue of entering and observing in the Hospital, I may have access to certain information of the hospital and patients therein, that is confidential and constitutes valuable, special and unique property of the Hospital. I will not at any time disclose to others, use, copy or permit to be copied without Hospital's written consent, any confidential or proprietary information of the Hospital, including but not limited to, any Protected Health Information (as defined at 45 CFR 160.103) or any private information of any patient or portion thereof, any hospital policies, procedures and/or protocols, or any other document that belongs to the Hospital.

I agree to abide by all requirements as stated in the OBSERVER AGREEMENT during my observation experience at University Medical Center of Southern Nevada.

I understand that I am responsible for any and all costs that pertain to required documents to observe at UMC.

Observer Signature:	
Date:	

MSS-301 (11/2015)

Request for Medical Observation Status

_____ (the "Sponsoring Physician"), a member of the Medical Staff of University Medical Center of Southern Nevada (UMC) hereby request for permission for (the "Observer") to accompany me at the Hospital and/or Ambulatory Care as only an observer for the following time period while I am providing patient healthcare services:

From _____(insert date) through _____ (insert date)
(Requests limited to a maximum of 30 days)

Reason for Observation:

The Observer:

☐ Physician

☐ Physician Assistant

☐ Medical Student; School Name: _____

☐ Other, please specify: _____

I understand that I am responsible for any and all costs that pertain to required documents to observe at UMC.

I attest that the Observer is not a Foreign Student.

I fully understand and hereby acknowledge that any disruption by the observer to the orderly operation of the Hospital or Ambulatory Care or any patient care activity, as determined in the sole and absolute discretion of the Hospital, shall result in immediate termination of the permission granted hereunder by the Hospital. Further, my signature below represents my understanding and acknowledgement that before the Observer may accompany me at the Hospital or Ambulatory Care, during the time period indicated, the Observer must first obtain approval by the Medical Staff Office by providing all required documentation.

We, the Sponsoring Physician and the Observer, hereby release and hold University Medical Center (and all of their officers, directors, staff, agents, representatives, employees, and their affiliated companies) harmless against any form of claim, suit, or action that may arise, either directly or indirectly, from the granting of the request sought herein.

Sponsoring Physician Printed Name: _____

Sponsoring Physician Signature: _____ Date: _____

Approved:

Chief of Staff Printed Name: _____

Chief of Staff Signature: _____ Date: _____

Print Name: Title:

Signature: Training Date:

Check one of the following:

☐ UMC Employee Enter Department / Unit: _____

☐ Resident / Student Enter School Name: _____

☐ Contractor from Enter Company Name: _____

☐ Volunteer

☐ Allied Health

Please check the correct answer for each of these questions:

1. What is the best resource to give to a patient regarding their privacy rights?
   a. Hospital Policy
   b. Notice of Privacy Practices
   c. The hospital website
   d. Both a and c

2. Where is the best place to quickly locate a copy of the Notice of Privacy Practices?
   a. Cafeteria
   b. Public Safety Officer
   c. UMCSN.COM under Privacy Policy
   d. Ask the Charge Nurse

3. I have accidently faxed part of a chart to Applebees. What is the first thing I should do?
   a. Submit a ticket to the IT help desk
   b. Retrieve the information
   c. Inform my manager when she arrives
   d. Send an email to the privacy Officer right before my shift ends

4. A patient state they received somebody else's discharge instructions. What is the first thing I should do?
   a. Retrieve the information
   b. Determine what unit the patient was discharged from
   c. Inform the Patient Advocate
   d. Determine if the patient was an inpatient, outpatient, or observation

5. Whose responsibility is it to know a patient's directory status prior to responding to

callers or visitors?

a. The hospital operator
b. Directory status is everyone's responsibility

6. A patient is listed as NFP in the hospital directory. I can direct a family member to the unit where the patient is located.

a. True
b. False

7. I am permitted to access the unit where a celebrity basketball player is staying if:

a. I am not disturbing the patient when I ask for a "selfie"
b. I just want to pass through to see if the player is actually here
c. I am assigned to the unit and I am starting my shift
d. I want to chat with my co-worker about the patient

8. I am permitted to use my badge to access hospital units when:

a. I am on duty and I have an operational need to access the unit
b. I am off duty but my family member is located in the unit

9. It is my responsibility to question or assist unknown or unescorted visitors to hospital units, even if they have a UMC badge.

a. True
b. False

10. Loose patient information that is not needed for the chart should be

a. Placed in a blue destruction bin
b. Torn up and placed in the trash
c. Carried in my pocket until I find the owner
d. Kept on the desk until I find the owner

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA

UMC PRIVACY and SECURITY PRACTICES

This digest summarizes appropriate personal conduct to ensure compliance with HIPAA's standards. See the Administrative Policy Manual and any department-specific policies and procedures for more information.

	DO	DO NOT
Access	— DO know who is allowed in restricted areas, allowed to see PHI, or allowed to use computers, — DO wear your UMC Badge at chest height at all times — DO look only at what you need to do your job.	— DO NOT allow unknown and unescorted persons In restricted areas, — DO NOT look at your, your family member's, or your friend's or neighbor's information. Never access patient information without a professional need to know.
Breaches	— DO immediately attempt to retreive PHI received by unintended recipients. — DO immediately report any known or suspected breach of PHI to the Privacy Officer, — DO immediately report lost or stolen devices used for UMC business to the IT Service Desk (2 2 2 7) .	— DO NOT allow unknown persons to access charts. — DO NOT access non-UMC databases without an appropriate reason.
Cameras	— DO use UMC-issued cameras for approved Identification, treatment, or education purposes.	— DO NOT Ignore faxes received in error, unattended records or papers with medial Information, or inappropriate posts to social media such as facebook, Twitter, Instagram, or YouTube.
Computers	— DO log off or lock computers when you leave them. — DO password-protect and use approved encryption software on any portable equipment such as laptops, smartphones, tablets, etc. — DO use strong passwords: at least 8 characters using letters, numbers and special characters that cannot be easily discovered.	— DO NOT discusss patient information with anyone who does not have a need to know. — DO NOT use personal cameras or mobile device cameras while at UMC. — DO NOT use unauthorized flash drives or disks. — DO NOT leave mobile equipment unattended. — DO NOT share passwords. — DO NOT use another user's log on. — DO NOT keep passwords where others can find them, — DO NOT visit Internet sites unrelated to your job. — DO NOT remove privacy screens from Workstations on Wheels (WOWs). — DO NOT allow patients to connect devices to the non-public UMC network. — DO NOT store PHI on computing devices. PHI *is* to be stored on UMC-managed servers and systems ONLY. — DO NOT utilize UMC electronic equipment for unauthorized purposes.
Copiers / Printers	DO keep in secured areas and utilize secure printing features. — DO remove copy and prints jobs immediately.	— DO NOT allow patients to utilize machines. — DO NOT leave copy or print jobs sitting on machines,

Disclosures — DO record any disclosure of PHI that Is not for routine treatment, payment, operations, or that has not been authorized by the patient,

— DO send all requests for copies of records to HIMD.

— DO NOT give patients copies of anything hut discharge instructions and prescriptions from the nursing units.

	DO	DO NOT
Disposal	— DO shred or use a locked blue recycle bin for paperwork containing PHI, — DO contact the Information Security Officer to wipe or physically destroy devices or media containing PHI.	— DO NOT overstuff destruction bins or leave them unlocked. — DO NOT leave bin keys unsecured. — DO NOT dispose of computers, smartphones, or tablets without appropriately wiping the device.
E-Mail & Messaging	— DO use the minimum necessary PHI in all messages. — ALWAYS use [Secure] to encrypt PHI before transmitting PHI outside of UMC. — DO protect messages from unauthorized viewers. — DO immediately report suspicious emails to IT. — DO verify email addresses before sending.	— DO NOT send unencrypted PHI outside UMC's network. — DO NOT send any PHI outside UMC's network without manager or IT approval. — DO NOT use PHI or identifiers in the subject line. — DO NOT open unknown attachments. — DO NOT click on links in suspicious emails. — DO NOT save or print messages via web mail access. — DO NOT send PHI via personal email accounts such as Gmail, Yahoo, Hotmail, or others.
Fax	— DO use a fax cover sheet. — DO double-check fax numbers before sending messages,	— DO NOT send faxes to unsecured locations. — DO NOT send faxes without verifying the recipient.
Patient Rights	DO respect patient rights granted by HIPAA: — Right to a Notice of Privacy Practices (NPP) — Right to object to some uses and disclosures; document their request. — Directory Restrictions - Know if a patient has requested any Directory Restrictions. Understand the privacy flags: NFP (Not For Publication) PASSWORD - Limit visitors and calls to those who know the password. — Right to Access — Refer patients to the Health Information Management Department for access to or copies of their records. — Right to an Amendment Refer patients to Health Information Management Department to have missing or erroneous records corrected.	— DO NOT discuss Information in front of visitors without the patient's consent. — DO NOT confirm the presence or give the location of any NFP patient. The recommended response is, "I'm sorry, there Is no information available for a patient by that name." — DO NOT create or divulge a patient's password.
Personal Mobile Devices	— DO subscribe to a service that can remotely wipe your personal device if lost or stolen. — DO subscribe to anti-malware for your device.	— DO NOT text or Instant message Identifiable patient Information. — DO NOT store PHI on your device.
Public Areas	— DO use the lowest voice possible for confidential discussions. — DO use a screen filter or be sure monitors are not visible to the public, — DO use cover sheets to shield PHI.	— DO NOT discuss or display protected information In public areas, e.g. the cafeteria or break room, — DO NOT display PHI on whiteboards or sign-in sheets.
Social Media	— DO report any patient information or hospital information posted on-line to the Privacy officer.	— DO NOT post any patient condition, treatment, or Identifiers on-line, even if your social media group is limited, — DO NOT mention or discuss patients that you have treated. — DO NOT mention the names of family members or friends of patients you have treated. — DO NOT post pictures of you or coworkers while at work,
Transport	— DO cover and secure PHI when transporting charts or reports.	— DO NOT remove any form of PHI from UMC unless authorized.

DO	DO NOT
— DO safeguard PHI from loss, theft, or unauthorized access when you are transporting PHI.	— DO NOT leave PHI or devices in vehicles. — DO NOT allow patients to maintain custody of UMC's original chart.

Record all disclosures as required, including errors and accidental disclosures.

Report any violations, threats, or suspicious activity to your supervisor and to the IT Service Center at 383-2227. You may also report to the Privacy Officer at 383-3854. The Hotline (AlertLine) can be reached at 1-888-691-0772, or via the link on the UMC Intranet Home Page,

Refer to the following for more Information:
UMC HIPAA Policies, Procedures and Resources, Administrative Policy manual, Clark County Privacy & Security Policy, and department-specific procedures: http://umc-polandproc/pAnsf
UMC HIPAA Forms: blip://umcintranet/hIpaaiinclexiasp
Office for Civil Rights - littp://www.hlisigoviocdprivacy/

Confidentiality Agreement

NAME: (PLEASE PRINT) _____

DEPARTMENT or AFFILIATION: _____ TITLE: _____

During the course of your activity at the University Medical Center of Southern Nevada (UMC) and its affiliates, you may have access to information which is confidential and/or proprietary. This information may not be accessed, used, or disclosed except as permitted or required by law and in accordance with UMC's policies and procedures. In order for UMC to properly care for patients, certain information must remain confidential. Improper access, use, or disclosure of confidential and/or proprietary information can cause irreparable damage to UMC, its patients and workforce members. Confidential and/or proprietary information that must be safeguarded from improper access, use, or disclosure includes, but is not limited to:

1. Any personally identifiable information relating the past or present provision of healthcare to an individual, eligibility of an individual for healthcare, or payment for the provision of healthcare to an individual.
2. Medical and certain other personal information about employees.
3. Medical Staff records and committee proceedings.
4. Financial and statistical records, strategic plans, internal reports, contracts, memorandums, peer review information, communications, computer programs, technology, source code, third-party information, client or vendor information, etc.
5. Other information protected by regulatory or legal requirements.

I understand, acknowledge and agree that:

1. It is my responsibility to use confidential and/or proprietary information as minimally necessary to perform my legitimate job duties at UMC.
2. I will not access any UMC electronic or other record relating to myself, any family member, friend, or acquaintance unless I have a legitimate need to know for the purposes of executing my assigned job duties at UMC, and only with written permission from my manager.
3. It is not permitted for me to obtain copies of records for myself, or anyone else, without submitting to the Health Information Management Department (HIMD) a valid authorization or other sufficient legal documentation demonstrating my authority.
4. I will not access any UMC electronic or other record relating to a public figure (including but not limited to entertainers, athletes, or prominent businesspersons, etc.) unless I have a legitimate need to know for the purposes of executing my assigned job duties at UMC.
5. If I am required to access non-UMC records or data to carry out my duties, I will not access this information without a legitimate need to know for the purposes of executing my assigned job duties at UMC.
6. I understand that moving or copying confidential and/or proprietary information from its secure source requires written permission from the data owner. Examples would include copying patient data to my workstation's hard drive, email account, or a USB storage drive. If approved, IT Security must be contacted to assist with securing the movement of the information.
7. I am obligated to hold confidential and/or proprietary information in the strictest confidence and not to disclose the information to any person or in any manner which is inconsistent with applicable policies and procedures of UMC, or with state or federal law.

8. I am obligated to immediately report any known or potential inappropriate access, use and/or disclosure of confidential and/or proprietary information to UMC in accordance with UMC policies and procedures.
9. I am obligated to comply with safeguards designed to protect the privacy and security of UMC's confidential and/or proprietary information consistent with applicable policies and procedures of UMC, and state and federal law.
10. I am obligated to ensure hard copies of confidential and/or proprietary information are securely stored in their designated location at all times, and are shredded or disposed of in designated shredder containers when no longer needed.
11. I am obligated to ensure printed or electronic confidential and/or proprietary information is never left unattended or exposed to unauthorized persons.
12. If I am issued a unique user code, it is my responsibility to maintain this code in a confidential manner. This user code is my signature for accessing computer systems. If I believe my unique user code is compromised I will immediately report that to UMC's Information Security Officer.
13. My access and use of all hospital computer systems and other sources of confidential and/or proprietary information is subject to routine, random, and undisclosed surveillance by the hospital.
14. Failure to comply with my confidentiality obligation may result in disciplinary action or termination of my employment or affiliation with UMC in accordance with UMC's standard policies for workforce sanctions for privacy and security violations.
15. Impermissible access, use or disclosure of confidential and/or proprietary information about a person may result in legal action being taken against me by or on behalf of that person.
16. I understand that licensed health care providers are subject to sanctions for impermissible access, use, or disclosure of confidential and/or proprietary information, including license revocation, suspension, probation and public reprimand.
17. Any intellectual property or idea developed by me at the direction of UMC, in furtherance of UMC business interests, and / or on UMC time, or any intellectual property or any idea derived there from, belongs exclusively to UMC.
18. My confidentiality obligation shall continue indefinitely, including at all times after the termination of my employment or association with UMC and its affiliates.

I have read and understand this Confidentiality Agreement, have had my questions fully addressed, and have had an opportunity to have a copy made for my permanent personal records.

_____ _____

Signature Date

Fair Employment Law Review

Anna Caputo -. Equal Opportunity Program Manager

First and Foremost

- All employees have the fight to work in an envitorunent that is free from discrimination,
- Each employee should conducthim/herself in a professional manner and demonstrate respect for colleagues, patients and visitors at all times.
- Supervisors and Managers must also:
  - -Monitor the workplace for discriminatory conduct and communication.
  - -Take all reports of discrimination seriously,
  - -Document and forward all allegations of fair employment law violations to the 110PM for direction and/or irtvestigatio4

UMC's Equal Opportunity/Affirmative Action Plan - What does it say?

- That our mission is to: create a workplace that reflects our community; recognize and respect the value of our unique personal characteristics and experiences; and support out diverse workforce In its goal of exemplifying Compassion, Accountability, Integrity and Respect.
- That UMC will not discriminate on the basis of race, color, religion, sex, age, national disability, sexual orientation, gender identity or expression, or genetic information in employment
- That UMC will not tolerate sexual harassment of a UMC employee by another employee, vendor, contracted service provider, or official of the hospital.

Fair Employment Laws (Protected Categories)

- Title VII of the Civil Rights Act of 1964, as amended: race, color, sex (includes gender identity/sexual orientation), religion, and national origin.
  - The Pregnancy Discrimination Act of 1978; pregnancy, childbirth, and related medical conditions.
- The Equal Pay Act of 1963 (EPA): men and women doing the sante work,
- The Age Discrimination in Employment Act (ADEA) of 1967: individuals age 40 and above.
- Title I of the Americans with Disabilities Act (ADA) of 199D, as amended.
- The Genetic Information Non:discrimination Act of 2008 (GINA)
- Nevada Revised Statutes (NRS 613.530); race, color, sex, religion, national origin, age, disability, sexual orientation and gender identity or expression.

Harassment and Sexual Harassment

- Harassment
  - Impermissible conduct may include, but is not limited to: offensive jokes; slurs; epithets or name calling; physical assaults or threats; intimidation; ridicule or mockery; insults or put-clowns; offensive objects or pictures; or interference with work pea on:nonce.
  - The law doesn't prohibit simple teasing, offhand comments, or isolated incidents that are not very serious, but harassment is illegal when it is so frequent or severe that it creates a hostile or offensive work environment or when it results in an adverse employment decision (such as the victim being fired or demoted).

- Sexual Harassment
  - Hostile Work Environment -practices ranging from unwelcome sexual advances, direct requests for sexual favors, and other verbal or physical harassment of a sexual nature, to workplace conditions that unreasonably interfere with an individual's job performance or create anintimidating or offensive working environment (for persons of either gender).
  - Qttid Pro Quo - submission to, or rejection of unwelcome sexual conduct is used as the • basis for an employment decision.

Discriminatory Employment Decisions if Based on a Protected Category

Recruitment	Hiring	Firing	Compensation
Transfer	Promotion	Layoff	Work Assignment
Recall	Other Terms and Conditions of Employment		

Also prohibited;

- Retaliation for filing a charge of discrimination, participating in an investigation, opposing discriminatory practices, or requesting an accommodation,
- Employment decisions based on stereotypes or assumptions about the abilities, traits, or performance of individuals due to race, age, etc.

Accommodations

- Disability an individual with a qualifying physical or mental impairment can request an accommodation to be able to perform the essential functions of his or her position, Each accommodation is determined on a case-by-case assessment; for example, an employee with diabetes may need regularly scheduled breaks during the workday to eat properly and monitor blood sugar and insulin levels, or an employee with cancer may need leave to have radiation or chemotherapy treatments. The test is whether the accommodationwould be en undue hardship on 'HMG
- Pregnancy: an accommodation request from a woman affected by pregnancy, childbirth or related medical conditions should be considered in the same manner as other employees similarly abled or disabled from working.
- Religion: an employer must accommodate the religious belief or practice of an employee unless doing so would pose an undue hardship (minimal burden). Examples of some common religious accommodations include flexible scheduling, voluntary shift substitutions or swaps, job reassignments, and modifications to workplace policies or practices, or allowing the use of particular head coverings or other religious dress.

Complaint Reporting Process

- Report the alleged misconduct to the immediate management team as soon as possible.
- Management should report the complaint to the ROM for appropriate action.
- Contact the EOPM directly.
- Pile a charge with an outside agency: UDC - (702)388-5099 or NERC - (702)486-7161
- Must be reported within 300 days from the last date of the alleged unlawful conduct.

See also UMC's Equal Opportunity/Affirmative Action Plan policy booklet on the EOPM Intranet page for more information, or contact the EOPM directly at (702)207-8264.

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Fair Employment Law Review
Acknowledgement

I acknowledge that I have read and reviewed the Information on the Fair Employment Law Review. I also understand that I am required to observe and abide by all rules, policies, procedures and standards associated with fair employment laws as they pertain to my job duties and/or presence at UMC, Including any that may be given to me In writing or orally in the future. I understand that while I am an employee, agent, or consultant of UMC, or engaged by UMC in any other capacity, I, may report any suspected fair employment law violation to UMC's Equal Opportunity Program Manager. I am also aware that I may file a complaint at any time with the Equal Employment Opportunity Commission or the Nevada Equal Rights Commission.

My signature below confirms my acknowledgement and understanding of the information contained in the Fair Employment Law Review,

Employee Name (Print) _____ Department _____

Employee Signature _____ Date _____

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MEDICAL STAFF

Operating Room Orientation for Observers

Name: _____

Hospital Department: _____

The Operating Room (OR) Orientation is mandatory for all non-physician observers, and must be completed prior to your Observation.

The one (1) hour OR Orientation can be scheduled by contacting the individual below:

> Ren Scott, MSN/Ed, BSHS/M, RN, CNOR Clinical Educator for Surgical Services @ (702) 383-7326 or by email at ren.scott@umcsn.com

OR Orientation is a scheduled event, by appointment only-and is generally provided from 7:00 am-8:00 am; however, appointments may be adjusted depending on Clinical Educator availability.

Please bring this form with you to OR Orientation

Observer's Signature: _____ Date: _____

Clinical Educator's Signature: _____

INSTRUCTION FOR THE UMC WEBSITE -- ON-LINE ASSOCIATE PRESENTATION
NON-PHYSICIAN & PHYSICIAN OBSERVER

Associate Presentation is located online:

https://www.umcsn.com/Careers/Associates.aspx

Click the website link (Non-Physician & Physician Observers) provided and complete the Associate Presentation. Upon completion, print out certificate along with any documentation needed. (Note: You must print or save certificate at time of completion, because you will not be able to re-access the certificate if you leave the screen.)

If any questions, please contact Evelia Olivero at (702) 383-2388 or email Evelia.Olivero@umcsn.com.

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
BACKGROUND SCREENING CONSENT FORM

Certiphi Screening, Inc.
Attn: Consumer Disclosure
P. 0. Box 540
Southampton, PA 18966
www.certiphi.com
(800) 260-1680

Applicant Full Name: _____
Any other Names used: _____
Social Security No._____ Date of Birth: _____
Current Address: _____
City: _____ State: _____ Zip: ____
Driver's License State _____ No._____
Address: _____
Have you ever been convicted of a crime? Yes _____ No _____
Offense _____ County_____ State _____ When ___
Please provide all locations where you have resided or practiced for the Past (10) years, starting with your current residency.

	City	State	Dates From:	To:
1.				
2.				
3.			/	/
4.				
5.				
6.			/	/
7.			/	/
8.			/	/

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

University Medical center of Southern Nevada may obtain information about you from a consumer reporting agency made in connection with your application for employment, contract or privileges. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living and which can involve personal interviews. These reports may contain information regarding your criminal history, social security verification, motor vehicle records ("driving records"), verification of your education or employment history, or other background checks. You have the right, upon written request made within a reasonable time after receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report. Please be advised that the nature and scope of the most common form of investigative consumer report obtained with regard to applicants for employment is an investigation into your education and/or employment history conducted by Certiphi Screening, Inc, 251 Veterans Way, Warminster, PA 18974; (800) 260-1680 or another outside organization. The scope of this notice and authorization is all-encompassing however, allowing the Company to obtain from any outside organization all manner of consumer reports and investigative consumer reports now and throughout the course of your employment, contract, privileges or appointment to the extent permitted by law. As a result, you should carefully consider whether to exercise your right to request disclosure of the nature and scope of any investigative consumer report.

The Age Discrimination in Employment Act of 1987 prohibits discrimination on the basis of age with respect to individuals who are at least 40 years of age. This information is necessary for the proper processing of a consumer report.

ACKNOWLEDGEMENT AND AUTHORIZATION

I acknowledge receipt of the DISCLOSURE REGARDING BACKGROUND INVESTIGATION and SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by the Company at any time after receipt of this authorization and throughout the term of my employment contract or privileges, if applicable. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by Certiphi Screening, Inc., 251 Veterans Way, Warminster, PA 18974; (800) 260-1680 another outside organization acting on behalf of the Company, and/or the Company itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

STATE LAW NOTICES

Minnesota or Oldahoma applicants or employees only: Please mark an X in the designated field if you would like to receive a free copy of a consumer report if one is obtained by the Company. The report will be mailed to the current address you indicated on this form. _____

California applicants or employees only: Please mark the following field if you would like to receive a copy of an investigative consumer report or consumer credit report at no charge if one is obtained by the Company whenever you have a right to receive such a copy under California law. The report will be mailed to the current address indicated above. _____

California applicants or employees only: by marking an X in the designated field, you will receive and are acknowledging receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW. _____

New York applicants or employees only: You have the right to inspect and receive a copy of any investigative consumer report requested by the Client by directly contacting Certiphi Screening, Inc. Additionally, please mark this field to receive and acknowledge receipt of a copy of Article 23-A of New York Correction Law. _____

Maine applicants or employees only: Under Chapter 210 Section 1314 of Maine Revised Statutes, you have the right, upon request, to be informed within 5 business days so such request of whether or not an investigative consumer report was requested. If such report was obtained, you may contact the Consumer Reporting Agency and request a copy.

Massachusetts applicants or employee only: if you ask, you have the right to a copy of any background check report concerning you that the Company has ordered. You may contact the Consumer Reporting Agency for a copy.

Washington State applicants or employees only: You have the right, upon written request made within a reasonable period of time after your receipt of this disclosure, to receive from the Company a complete and accurate disclosure of the nature and scope of the investigation we requested. You also have the right to request from the consumer reporting agency a written summary of your rights and remedies under the Washington Fair Credit Reporting Act.

I have read and understand the above information and assert that all information provided by me is true and accurate.

Signature: _____ Date: _____

The Age Discrimination in Employment Act of 1987 prohibits discrimination on the basis of age with respect to individuals who are at least 40 years of age. This information is necessary for the proper processing of a consumer report.

VISITING OBSERVER AUTHORIZATION FORM

As part of its mission as a community and teaching hospital, UMC sometimes accepts Observers from the community who are interested in health care services or seek to expand their knowledge of health care. This Authorization is for Visiting Observers that are not Student Observers or Healthcare Provider Observers.

YOU CAN REFUSE AN OBSERVER AT ANY TIME, EVEN AFTER SIGNING THIS AUTHORIZATION.

By signing this Authorization, you are giving permission for a Visiting Observer to observe your interactions with health care providers at UMC. This will potentially include you in your room or other treatment areas in UMC, your conversations with health care professionals, health care professionals' discussions about you, and treatment or other procedures related to you. Observers will likely see your face and hear your name, they will be in your presence. Observers may see parts of your medical record if the Physician Provider allows the Observer to see a part of the record (such as an X-Ray or other image) as part of the observation experience.

All Visiting Observers are required to protect the privacy and confidentiality of any treatment or health information that they may observe. Observers will not receive copies of any records related to you. Observers are not permitted to photograph or record any part of their observation experience.

Observation Start Date: _____

Observation End Date: _____

Visiting Observer Name: _____

This Authorization ends on the 'Observation End Date' noted above. Authorizing this observation is voluntary and I may refuse to sign this document. Treatment, payment, or eligibility may not be conditioned on whether I sign this Authorization. Any information disclosed pursuant to this Authorization may be subject to re-disclosure and therefore no longer protected by federal privacy regulations.

I may refuse an Observer or revoke this Authorization at any time. Refusal or revocation may be made verbally with your health care team. Revocation can also be made in writing to the UMC Health Information Management Department at: 1800 W. Charleston Blvd., Las Vegas, NV 89102. Refusal or revocation will not apply to information already disclosed pursuant to this Authorization.

By signing this Authorization below, I hereby acknowledge that I have read, understood, and agreed to the statements contained herein:

Patient Name: _____

Patient Signature: Date: _____

Patient Representative's* Name:

Representative's Signature: Date: _____

*Guardian or Durable Power of Attorney for Healthcare paperwork should be reviewed and included with this request.

CONSENT AND STATEMENT OF APPLICANT FOR OBSERVATION

(Please read carefully before signing)

I understand and acknowledge that, as an applicant to observe at University Medical Center of Southern Nevada (UMC), it is my responsibility to provide sufficient information upon which a proper evaluation of my qualifications, including my current licensure, relevant training and/or experience, character and ethics, can be made.

I further understand and acknowledge that UMC to which I am applying for observation will verify the information in this application.

By submitting this application, I hereby authorize UMC and their agent to consult with administrators and members of the medical staffs of other hospital or institutions with which I have been associated and with others who may have information bearing on my professional competence, character and ethical qualifications.

I understand and acknowledge that completing this application does not entitle me to observe at UMC. I further understand and acknowledge that UMC shall be solely responsible for all decisions concerning my application for observation.

Verification of Application for Observation : I hereby authorize all individuals and entities (past, present, and future), who have knowledge concerning my professional competence, character, ethical qualifications, malpractice claims, settlements, and judgments and other information requested in this application to consult with, and release relevant information and records to, the medical staff and the agent of UMC.

I further authorize the use of the photographs provided by me both for internal and external procedures relating to verification.

I also hereby authorize all federal, state and local law enforcement and other agencies to consult with and to release to UMC, through its Medical Staff Office and its agents, all information and records regarding criminal charges, convictions and sentencing matters relevant to the applicant.

Authorization of Release. I understand and agree that the authorization given by me herein shall be irrevocable for a period of twenty-four (24) months, from the date it is signed. A photocopy of this waiver shall be as effective as the original when so presented.

All information provided by me, in the Application for Observation, is true to the best of my knowledge and belief. I understand and agree that any material misstatement in or omission from the application may constitute grounds for denial of observation status. I further acknowledge that I have read and understand the foregoing Authorization.

I hereby further release from liability all representatives of UMC, the Board and medical staff. I further release all medical schools, hospital, licensing Boards, specialty societies and all other entities and individuals providing information from liability for their acts performed in connection with the gathering and exchange of information as consented to above.

I agree to notify UMC, through the Medical Staff Office, of any circumstances arising subsequent to the date of this application that would change any of the responses I have given in this application.

I agree to notify UMC, through the Medical Staff Office, immediately upon notification to me of any suit or claims alleging malpractice or malfeasance against me. I agree to notify UMC, through the Medical Staff Office, immediately upon notification to me of any information relating to any disciplinary action, suspension, or curtailment of surgical/medical privileges at any facility where I may have or will apply for privileges.

ALL INFORMATION PROVIDED IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

NAME OF APPLICANT (PRINT): _____

SIGNATURE OF APPLICANT: _____ DATE: _____