Nicklaus Children's Health System

Where Your Child Matters Most™

Observer Program Application

Applicant Name (print): Date of Birth: Age:

Phone #: Email Address:

Current Address:

City: State: Zip:

Citizen or permanent resident of the U.S.?

☐ Yes ☐ No if 'No' country of residency

Emergency Contact Name:

Emergency Contact Phone #:

- ☐ High school student* Observations only during the summer (June-August)
- ☐ Not currently enrolled in school or training program
- ☐ Graduate student (allied health, nursing, pharmacy, administrative etc.)
- ☐ Undergraduate student (allied health, nursing, pharmacy, administrative etc.)
- ☐ Pre-Med
- ☐ Other:

Are you now, or have you ever been, an employee of Nicklaus Children's Health System?

☐ Yes ☐ No

• If yes, which entity and what was your last date of employment (or current)?
Entity: Date:

For the Sponsor: Place a check mark next to each facility the observation will take place.

You may select facilities where you have clinical privileges or are employed.

- ☐ Nicklaus Children's Hospital (Main Campus)
- ☐ Nicklaus Children's Miami Lakes Outpatient Center
- ☐ Nicklaus Children's Boynton Beach UCC
- ☐ Sports Health Center
- ☐ Dental Mobile Unit
- ☐ Doral Outpatient Center
- ☐ Dan Marino Outpatient Center
- ☐ Nicklaus Children's Miami Lakes Outpatient Center
- ☐ Nicklaus Children's Nirvair Chowdhury Midtown Center

- ☐ Nicklaus Children's Hialeah UCC
- ☐ Nicklaus Children's Miramar Outpatient Center
- ☐ Nicklaus Children's Homestead UCC
- ☐ Doral Pediatric Dental Services
- ☐ Nicklaus Children's Palm Beach Gardens Outpatient Center
- ☐ Nicklaus Children's Palm City
- ☐ Nicklaus Children's Palmetto Bay UCC
- ☐ Nicklaus Children's Sports Health Center Pinecrest
- ☐ Nicklaus Children's West Bird
- ☐ Nicklaus Children's West Kendall UCC

There is NO access to observe in an operating room and psychiatry department at any time.

Observational period (mm/dd/yy) From: To : (maximum four weeks)

Sponsor Name: Department/Specialty:

Sponsor E-mail: Mobile #:

City: State: Zip:

Sponsor Signature: Date:

If shadowing multiple sponsors, please list them below:

NAME	SIGNATURE	DATE

Department Director Name*:

Signature: Date:

**Shadowing a nurse requires the approval of the department Director or above.

Acknowledgement of Confidentiality

Nicklaus Children's Health System takes seriously its obligations to maintain the confidentiality of patient information under federal and Florida privacy laws and regulations. As a participant of this program at a Nicklaus Children's facility, you may inadvertently encounter patient information or organizational information because of your presence at a Nicklaus Children's facility. By signing below, you acknowledge that, as a condition of your presence at a Nicklaus Children's facility, you have read and agree to comply with our policies and procedures regarding the confidentiality of patient and business information, and the requirements set forth in this program handbook. Further, you agree not to record, discuss or otherwise divulge any patient or business information that you may come in contact with during your time in the program.

Consent to Participate and Release

I give full and knowledgeable consent to fully participate in the Observer Program. I understand that there are inherent risks involved with this program that Nicklaus Children's cannot totally eliminate (including, but not limited to, exposure to infection, injury, unpleasant sights, sounds, odors, etc.) and by signing this do hereby agree to understanding those risks. Furthermore, by signing this I do hereby release Nicklaus Children's Health System, and any and all other agencies, personnel, or others involved from any and all liability including, but not limited to, injury or illness that may occur during or after participation in this program. Applications from current and former employees will not be accepted for this program.

I certify that I have read and understood all materials in the program handbook and application, including, but not limited to, all policies and procedures established and referenced within, and agree to abide by all such policies and procedures. I understand acceptance to the program is contingent on submission of all requested materials and meeting all eligibility requirements as determined by Nicklaus Children's. I understand the Observer Program is a voluntary experience that does not constitute employment or promise of future employment, medical education or any training leading to academic credit, licensure or board certification.

Applicant Name: _____

Applicant Signature: _____ Date: _____/_____/_____

If under 18 (programs only for observers 16 years old or older)

Parent or Legal Guardian Name: _____

Signature: _____ Date: _____/_____/_____

Application Checklist

Please return all documents listed below to the Learning and Development Department by email at *ObservationProgram@Nicklaushealth.org* two to eight weeks prior to the start of the observership unless circumstances allow a reduced time as approved by the facility. Observership may not begin prior to clearance and notification from the Learning and Development Department.

- ○ Two-page program application completed and signed by sponsoring clinician/individual
- ○ Immunization records, including a Tdap vaccine from the past 10 years
- ○ Copy of government-issued photo ID (driver's license, passport, military ID, etc.)
- ○ Students: Proof of enrollment on school letterhead or email
- ○ U.S. Citizen/Resident: Confirmation of successful background check within 1 year OR clearance letter from police department from county of residence
- ○ Administrative fee paid (cc payment accepted ONLY) (waived for current high school students) please email *ObservationProgram@Nicklaushealth.org* for payment details.

Application:
Email application to: **ObservationProgram@nicklaushealth.org**

Administrative fee:
Credit Card Only: arrange payment by emailing **ObservationProgram@Nicklaushealth.org**

Nicklaus Children's Health System
Where Your Child Matters Most™