Houston Physicians' Hospital
Observer Application

Individuals desiring to observe at Houston Physicians' Hospital (the "Hospital") must be:

- At least 16 years old and provide proof of age in the form of a driver's license, passport, or state-issued identification card
- Have a sponsor (hospital employee or physician) who is willing to allow observation in their clinical practice. *The hospital will not make these arrangement on the observer's behalf.*
- Be one of the following:
    - Physician
    - Allied Health Professional
    - Licensed clinician (RN, Respiratory Therapist, Physical Therapist, etc.). *Proof of active license required.*
    - Student

Name: ____ Date: ____________________________________

Cell Phone: ____ Email: ___________________________________

Current License (type and number): ____

Are you related to your sponsor? ☐YES ☐NO

Name of staff member (sponsor) you wish to observe: __________________________Department: ____________

Are you a vendor? ☐YES ☐NO Are you a student? ☐YES ☐NO

Name of School: ____ Program: ___________________________

Date(s) you wish to observer: From________________________________To_______________________________

Reason/Intent of Observing: ____

By signing below, the parties affirm that they will each adhere to all hospital policies concerning patient safety, privacy, and confidentiality and the Observer will be under the direct observation of their medical or allied health staff member (sponsor) at all times. No privileges to provide patient care are granted under this Agreement. The medical or allied health staff member who agrees to sponsor the individual agrees to obtain patient consent & assume full responsibility for the Observer's actions during the time of observing. Observer agrees to bear all risks related to his/her participation as an Observer at the Hospital and waives all claims against the Hospital. Observer agrees to indemnify, defend and hold harmless the Hospital, its employees, contractors, agents and medical staff members, from and against any expense, loss, liability or consequential damages as a result of breach of obligations under the signed Agreement.

Observer Name (printed): ____ Date ________________________

Observer Signature____

Sponsor Name (printed): ____ Date ________________________

Sponsor Signature__________________________________ Sponsor Email _________________________________

Senior Leader Signature ____Date ________________________

The Clinical Educator must receive completed application, 72 hours in advanced of the requested observation date.
You will be notified by email or phone if you are accepted.