Thank you for interest in shadowing/observing at 1917 Clinic.

We place many students at 1917 Clinic through agreements with various professional schools (medicine, nursing, pharmacy, nutrition, etc.) These students who are required to complete rotations for degree requirements receive priority.

We do have limited opportunities for other students who are exploring healthcare options and wanting to gain experience in a clinical setting.

In order to be aware of all of our clinic visitors and to comply with healthcare and HIPAA regulations, all interested observers must read the Observer Orientation Manual and complete the checklist below prior to being assigned.

☐ 1917 Clinic Contact Information
☐ Code of Conduct Attestation
☐ Confidentiality Agreement
☐ Assumption of Risk and Hold Harmless Agreement
☐ HIPAA Training (if you plan to observe five days or greater)
  o I do not plan to observe more than four days.
  o I do plan to observe more than four days:
    □ UAB Affiliated Observers – Please attach HIPAA Training Certificate
    □ HIPAA Training – We will assign online training. Look for an email from Sheila Searson.
☐ Employee Health Clearance (if you plan to observe five days or greater)
  o I do not plan to observe more than four days.
  o I do plan to observe more than four days. (See next page.)
☐ Physician Observer Agreement (for Physicians Only)
☐ Current Resume or CV
☐ 1917 Clinic Visitor Request Information (if you have not been assigned by your department/school/institution)
Employee Health Clearance

If observing for five days or greater, Employee Health must clear you to observe before we can schedule you to observe. They take appointments between 8:00am – 4:00pm any day of week except Thursday’s. Please provide 2-3 dates and times you can go to Employee Health. Please allow at least one week to get an appointment scheduled and at least two weeks before you wish to observe.

- Date and Time 1: _________________________
- Date and Time 2: _________________________
- Date and Time 3: _________________________

When you submit all Observer Paperwork, we will contact Employee Health. We will confirm the date and time and location with you. When you have been cleared, Employee Health will notify us, and we will follow-up to place you.

Other Details:

Parking: The 1917 Clinic is located at 908 20th Street S. Parking is very limited around the clinic. If you have designated parking at UAB, please plan to walk from that lot. Metered parking exists on surrounding streets and a parking deck is accessible on University Blvd near 19th Street. Do NOT park in the Patient Parking Lot behind the clinic.

Dress Code: Dress is business casual (no denim). Scrubs are acceptable if they are your normal professional dress. Wear closed-toe shoes. If you have a UAB ONE card, please wear this on the upper part of your body. If you do not have a UAB ONE card, we will issue you one if you are here five days or longer. Please no personal cell phone use unless you have been instructed by a provider or have an emergency.

Arrival: Please come to the 1917 Clinic front desk on your first visit.
- Notify the front desk of the name of the provider or staff member that you have been assigned to observe.
- On all visits, please sign in the Visitor Log Book located at the front desk.
- On your first visit, complete the Observer Review of Symptoms Form – bring the copy in the manual or find one in the Visitor Log Book.

If you have any questions or need to make changes to your schedule, please contact Shirley Selvage, our Visitor Coordinator, at sselvage@uabmc.edu or me at kellyrossdavis@uabmc.edu.

We look forward to having you at 1917 Clinic.
Kelly Ross-Davis, Education Director, 1917 Clinic
The University of Alabama at Birmingham
Outpatient Clinic • 908 20th Street South
Birmingham, AL 35294-2050 • 205-934-9253 • FAX 205-934-8490
Full Name ____________________________________________

Preferred Name ______________________________________

Street Address _________________________________________

City, State, Zip _________________________________________

Email Address __________________________________________

Phone, home ______________________________ Phone, cell ______________________________

Emergency Contact 1 ______________________________ Emergency Phone 1 ______________________________

Emergency Contact 2 ______________________________ Emergency Phone 2 ______________________________

Purpose of visit: (please include University attending, academic interests, degrees earned or other pertinent information to ensure appropriate placement at the 1917 Clinic)

Are you employed by UAB Hospital or HSF Facilities/Clinics? No Yes
Are you a physician or dentist? No Yes (If yes, be sure to complete the Physicians Only Packet)
Are you a student at UAB? No Yes School: __________________ Blazer ID: ________________

Requested Location of Assignment:
Department (e.g., Provider, Nursing, Social Work, Research, Dental, CORE) __________________ Departmental contact __________________

Title __________________________ SSN __________________________

Date of Hire __________________________ Date of Birth __________________________

Physicians

DEA # __________ NPI # __________ AL license # __________
1917 Clinic Visitor Request Information

**Type(s) of Provider you would like to shadow:**

- [ ] Physician
- [ ] Nurse Practitioner
- [ ] Dentist
- [ ] Nurse
- [ ] Social Worker
- [ ] Dietician
- [ ] PrEP Clinic (Friday 1-3pm)
- [ ] Prevention Educator
- [ ] Other (including non-HIV clinics): _____________________________________________
- [ ] CORE (Complete CORE application)

**Dates you would like to shadow.** Note that our clinic is open Monday – Thursday, 7:30am – 5pm, Friday, 7:30am – 3pm. We have morning (8-12) and afternoon (1-5) clinics. Please be specific as to what days you are available.

Preferred Dates/Month/Semester:

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

<table>
<thead>
<tr>
<th>Day of the Week</th>
<th>Morning (8-12)</th>
<th>Afternoon (1-5)</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
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<tr>
<td>Friday</td>
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</table>

**Number of times you would like to shadow.** Typically, this is a total of one to four times. If you would like to request more than four days, please be sure to complete the HIPAA Training and Health Clearance.

- [ ] One
- [ ] Two
- [ ] Three
- [ ] Four
- [ ] More than four: _______________________

**Reason(s) you would like gain shadowing experience in an HIV Clinic specifically.**

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
UAB Enterprise Code of Conduct Attestation

These questions are your acknowledgement of having read and understood the Code, as well as commitment to the Code and the expectation of raising questions or concerns about applicable laws, regulations, and policies.

Having reviewed the UAB Enterprise Code of Conduct, please place a checkmark next to the following statement(s) to indicate your agreement.

1. I have read and understand the UAB Enterprise Code of Conduct, and I agree to abide by this Code.

   Use an X to indicate the correct answer.
   
   □ Yes
   □ No

2. I understand that, as a member of the UAB community, I am expected to raise questions or concerns about applicable laws, regulations, and policies to the appropriate university official through either my immediate manager or a manager at a higher level within my unit, Human Resources, a compliance officer, or the UAB Ethics Matters Hotline. The UAB Ethics Matters Hotline is available 24 hours a day, 7 days a week at 1-866-362-9476.

   Use an X to indicate the correct answer.
   
   □ Yes
   □ No

Print Name

Signature

Department

Date

If you answer "no" to either of the above questions, meet with your sponsor to address concerns before starting your observership.
Confidentiality Agreement Form

IMPORTANT:
Read all sections. If you have any questions, please ask them before signing. You will receive a copy of this Agreement and a copy will be placed in your personnel/academic program file.

- DISCLOSURE OF PROTECTED HEALTH/SENSITIVE INFORMATION –
I recognize that the services provided by UAB and UAB Health System and their Operating Entities (collectively referred to as "UAB") for its patients are private and confidential; that to enable UAB to perform these services, patients furnish information to UAB with the understanding that it will be kept confidential and used only by authorized persons as necessary in providing these services; that financial information, personnel data, trade secrets, and other sensitive information shall also be kept confidential; that the good will of UAB depends upon keeping this information confidential; that certain moral, ethical, and legal obligations are attached to this information; and that by reason of my duties or in the course of my employment or training I may receive or have access to verbal, written, or electronic information concerning patients, finances, personnel data, trade secrets, other sensitive information, or services performed by UAB even though I do not furnish the services or have direct access to the information.

I hereby agree that, except as directed by UAB or by legal process, I will not at any time during or after my employment, training, observing, or during my duties at UAB, disclose any such services or information to any unauthorized person, or permit any such person to examine or make copies of any reports or other documents prepared by me, coming into my possession or control, or to which I have access, that concerns UAB in any way. I agree that I will not attempt to use any such information for my own advantage.

I recognize that the unauthorized disclosure of information by me may violate state or federal laws and do irreparable injury to UAB or to the patient, and that the unauthorized release of information may result in disciplinary action being taken against me, up to and including termination of employment or assignment. Civil and criminal penalties may be brought against me as a result of my unauthorized disclosure of information.

- SECURITY OF UAB INFORMATION/EQUIPMENT -
I agree that I will comply with all security and privacy regulations, standards, policies, and procedures in effect at UAB.

I understand that all software used on a computer owned by UAB must be properly licensed and approved by UAB Administration for use on that computer. The use of unlicensed or unapproved software constitutes a serious risk to UAB operations. If I use or allow the use of any unlicensed or unapproved software or computer game on a UAB computer, I will be subject to disciplinary action or dismissal.

UAB computer applications are communication systems allowing you to retrieve protected health information or other sensitive data.

I understand that my user account is equivalent to my legal signature, and I will be accountable for all work done under this account. I acknowledge that my use of UAB information resources may be monitored/audited. I will not disclose my user account to anyone, nor will I attempt to learn another person's account. I will not access data on patients, finances, personnel, or trade secrets for which I have no responsibilities and for which I have no "need to know." If I have reason to believe that the confidentiality of my user account has been breached, I will immediately contact my information services department.

By receiving a user account, I acknowledge and understand that I am responsible for proficient use of UAB computer applications. I further acknowledge and understand that my proficiency in using UAB computer applications is a condition of continued employment in my position and that failure to reach the required level of proficiency for my position within a reasonable time will bring about termination of employment. If I do not fully understand the application functions, I may contact my information services department for assistance.

I acknowledge that I have been made aware of UAB's confidentiality of information standards. I have read all of the above Sections of this Agreement, and I understand them.

Name (please print)  Position/Title  School/Department

__________________________  ____________________________  ____________________________
Signature                                      Date                      Unit

Signature of Witness  Date

Please indicate your role at UAB:
Employee  Volunteer  Independent Contractor  Business Associate
Temporary Employee  Student  Vendor  Other
Assumption of Risk and Hold Harmless Agreement

For, and in consideration of being permitted to participate as a volunteer/observer/shadow at any entity of UAB Medicine, I, the undersigned, in full recognition that a hospital/clinic environment may present various risks to health and safety, assume all the risks and responsibilities of my participation as a volunteer/observer/shadow, and any activities undertaken are adjunct thereto. Further, I do, for myself, my heirs, and personal representative(s) hereby agree to hold harmless, release, and forever discharge the Board of Trustees of the University of Alabama (the Board), the University of Alabama at Birmingham (UAB), every division thereof, including, but not limited to UAB Medicine entities, and all officers, employees, and agents, and the University of Alabama Health System, from any and all claims, demands, and actions, or causes of action, on account of damage to personal property, personal injury or death, which may result from my participation as a volunteer/observer/shadow, and which result from causes beyond the control of, and without the gross negligence of the Board and UAB, its officers, employees or agents, and/or the University of Alabama Health System, during the period of my participation as a volunteer/observer/shadow at the UAB Medicine entities.

In witness whereof, I have caused this Assumption of Risk and Hold Harmless Agreement to be executed on this _______ day of _________, 20____

__________________________________  ______________________
Signature of Participant                  Date

__________________________________  ______________________
Signature of Patient/Guardian, if Participant Date

__________________________________  ______________________
Signature of UAB Medicine Sponsor       Date
Attachment B

UAB MEDICINE
UAB HOSPITAL & AMBULATORY

Observer Review of Symptoms Form

Please complete the first date of the visit and fax the completed form to UAB Hospital Employee Health 975-6900.

Name of Observer______________________________ Today’s Date ____________________________

Observer’s Date of Birth ___/___/_______ SSN# _____-____-_____ 

Location of the Observership ________________________________________________________________

Please review with the Observer and refer to Employee Health for evaluation if the answer is “Yes” to any of the questions. This does not necessarily mean the Observer cannot proceed with the planned activity.

1. Any rash that is present within the last 2 weeks? □ Yes □ No

2. Fevers (temperature ≥38.3C or 101.5F)? > 24hrs □ Yes □ No

3. Persistent Cough? □ Yes □ No

4. Any Upper Respiratory Infection Symptoms like Influenza (coryza, eye pain, sore throat, sneezing?) □ Yes □ No

5. Anorexia, hemoptysis, unintended weight loss in the last few weeks? □ Yes □ No

6. Current skin or soft tissue infection requiring treatment with systemic antimicrobials? □ Yes □ No

7. Active lice, scabies, or other mite infection? □ Yes □ No

8. Nausea, Vomiting or Diarrhea in the past 3 days? □ Yes □ No

If any of the above symptoms occur during the period of the Observer’s visit, please ask the Observer to contact Employee Health Immediately at 934-3675.

____________________________________________________________________

Please Print Name of Sponsor ___________________________ Signature of the Sponsor ___________________________

Observer Orientation

Packet Page 19
Observer Checklist Form

IMPORTANT: Read all sections. If you have any questions, ask before signing. You will receive a copy of this Agreement.

I. Bloodborne Pathogen/Aseptic Technique
   • Bloodborne pathogens are pathogenic microorganisms that are present in human blood/body fluids and can cause disease in humans. These pathogens include, but are not limited to, hepatitis B virus (HBV) and human immunodeficiency virus (HIV).
   • Observers should not handle or touch any blood or body fluids.
   • Observers should report to the supervisor of the area for instructions related to special precautions that should be taken during observation. This includes, but is not limited to, attire, aseptic technique, and departmental regulations that apply to visitor observation.
   • Observers must respect the basic principles of aseptic technique. These principles include prevention of the contamination of the open wound, to isolate the operative site from the surrounding unsterile physical environment, and create and maintain a sterile field in which surgery can be performed safely. This may be achieved by strictly observing instructions given by the charge nurse. At no time should the observer stand near a sterile field or attempt to touch any items (clean, sterile, or dirty) that are used for patient care.
   • It is vital that patients are protected from unexpected complications that could be caused by accidental contamination of the surgery or procedural area. It is also vital that observers are not exposed to bloodborne pathogens during observation in the Clinical areas. In order to ensure safety and protection for the patients, observers and visitors, certain guidelines must be followed.

II. I have read the above statement, signed all required forms and agree to abide by all relevant UAB Medicine standards of conduct and policies and procedures, to include policies regarding photography and confidentiality of information, while they are observing in Clinical Facilities.

I understand failure to comply may result in my immediate removal from the Clinical Facilities and restrictions on any future opportunities to observe.

<table>
<thead>
<tr>
<th>Orientation Checklist</th>
<th>Date completed</th>
<th>UAB Medicine Liaison Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Those observing five days or longer must be cleared by Employee Health prior to starting their orientation and the start of their observership. Call: 934-3675. <strong>Recommend: contact 2 weeks prior to start.</strong></td>
<td>☐ Not Applicable ☐ Employee Health ☑ Appt ☑ Cleared</td>
<td></td>
</tr>
<tr>
<td>Observer Orientation Packet Provided</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Code of Conduct Attestation Form (Page 16)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confidentiality Agreement Signed (Page 17)</td>
<td>Date</td>
<td></td>
</tr>
<tr>
<td>Assumption of Risk and Hold Harmless Agreement (19 years of age or less must have parent's signature) (Page 18)</td>
<td>☐ Not Applicable ☐ Date</td>
<td></td>
</tr>
<tr>
<td>Observer Badge Provided by Department must be visible at ALL times and must include: the UAB Medicine Entity Name, Observer's Name and Date(s) Observing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Observer Review of Systems Form faxed back to Employee Health on the first day of the observer visit. Fax 975-8900. (See page 19 of this packet.)</td>
<td>Date Faxed (Must be 1st Day of Visit)</td>
<td></td>
</tr>
<tr>
<td>HIPAA Training -If observing 5 days or longer, contact UAB Privacy Office, Health System Information Services 996-5051 for additional training required.</td>
<td></td>
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</tr>
</tbody>
</table>

This Observer has completed orientation, signed all required forms and their request to observe has been approved for __________ (date) __________ (not more than 60 days). A copy of this complete form has been given to the observer.

Approved by: ____________________________ Title: _______________ Date: _______________  
Sponsor Signature: __________________________ Title: _______________ Date: _______________
Park in 4th Avenue South Deck. Pay to exit.

Enter here, Employee Health is in Spain Wallace, Suite 123, which is close to this entrance.

UAB Hospital Employee Health, be sure to take any documents related to TB test or immunizations. At least have your immunization history. Appointment cannot be made on Thursdays, since a TB test, if given, has to be read 48-72 hours later (into the weekend). Employee Health 934-3675.