Lima Memorial HEALTH SYSTEM

# STUDENT REQUEST FOR OBSERVATION EXPERIENCE
# INCLUDING PATIENT ROOMS

_____
(Date)

Dear Parent:

Your _____ , _____ , has requested to observe
(Student's Relationship) (Student's Name)

_____, during the_____shift on_____. In order for
(Unit and Position) (Shift Time) (Date)

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

- Hold LMHS harmless and indemnify LMHS for any personal injury incurred by_____(student's name) during this period of observation.
- Assume responsibility for student conduct and attendance.
- Assume responsibility for confidentiality of information the student may become aware of during the observation period. It is of utmost importance that the student understands that any information they are exposed to in the LMHS setting in regard to patients must not be shared with anyone in the community. Associate will indemnify LMHS for any loss in this regard.
- Assure that to the best of your knowledge, your child has not been exposed to any communicable diseases such as chickenpox, measles, etc. within the last three (3) weeks.
- For infection control reason,_____is not permitted to:
(Student's name)
  1. have direct, hands-on patient contact during the observation period
  2. move unsupervised about LMHS

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 patients' 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.

Attire for the day, will be required to follow LMHS Dress Code policy.

Thank you for choosing Lima Memorial Health System.

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| Educator's Signature | Date | Parent or Guardian's Signature | Date |
| Student's Signature | Date | Associate Signature if Non-Parent | Date |
| LMHS Representative Signature | Date | | |

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