Exhibit A

NORTH BROWARD HOSPITAL DISTRICT
d/b/a BROWARD HEALTH

OBSERVATIONAL EXPERIENCE APPLICANT CHECKLIST

This form must be completed in its entirety and returned to the Medical Staff Office(s) where you have requested to observe. Observerships may not commence until you have been approved and notified by the Medical Staff Office(s).

Name	
Phone Number	
Email Address	
Date of Birth	
Social Security Number	
License Number (if applicable)	
Type of License (if applicable)	
Hospital Location Requested	
Area / Department Requested	
Physician Observing	
Physician Specialty	
Dates of Observation	
Reason for Observation	

Along with this form, you must also provide the following. Visit https://doctor.browardhealth.org for details.

- ☐ Copy of your U.S. government-issued photo ID (i.e. driver's license, passport)
- ☐ Copy of your health insurance card
- ☐ Observational Experience Request and Agreement
- ☐ Observational Experience Sponsoring Physician Agreement
- ☐ Observational Experience Acknowledgement
- ☐ Observational Experience Influenza Vaccine Survey
- ☐ Certificates of Completion of all required online orientation modules
- ☐ Copy of negative TB test results or negative chest x-ray
- ☐ Confidentiality and Data Security Agreement

Please refer to https://doctor.browardhealthorg for contact information if you have questions or need assistance.

Exhibit B

BROWARD HEALTH

NORTH BROWARD HOSPITAL DISTRICT
d/b/a BROWARD HEALTH

OBSERVATIONAL EXPERIENCE REQUEST AND AGREEMENT

By completing this form, all parties named below hereby request participation in an observational experience within the Broward Health system. All parties have read the Broward Health policy entitled "Observers in Broward Health Hospitals" and agree to abide by said policy at all times during the observational time period to be approved. Any questions or concerns during said time should be brought to the attention of the Medical Staff Office.

Observer:____

Signature Print Name Date

Sponsoring Physician:______________________________________

Signature Print Name Date

Requested Hospitals:

- ☐ Broward Health Medical Center/Broward Health Children's Hospital
- ☐ Broward Health North
- ☐ Broward Health Imperial Point
- ☐ Broward Health Coral Springs
- ☐ Broward Community Health Services

Dates to Observe:
From __/__/__ to __/__/__
(*Not to exceed four weeks*)

------- ***FOR HOSPITAL USE*** -------

Received By Medical Staff Administration:

____

Signature Print Name Title Date

Approved As Requested?

- ☐ Yes
- ☐ No
- ☐ With Conditions

Conditions:

____
____
____

This form must be approved by at least one medical staff representative and one hospital senior executive (as designated by the Hospital CEO).

Approved By Hospital Senior Executive:

____

Signature Print Name Title Date

Approved By Medical Staff Representative:

____

Signature Print Name Title Date

Approval Communicated by Medical Staff Administration to:

- ☐ Observer
- ☐ Sponsoring Physician
- ☐ Hospital Staff
- ☐ Other

Method:________________
Date:__________________

Exhibit C

NORTH BROWARD HOSPITAL DISTRICT
d/b/a BROWARD HEALTH

OBSERVATIONAL EXPERIENCE SPONSORING PHYSICIAN AGREEMENT

I, ________________________________ ("Sponsoring Physician") am an active member in good standing of the medical staff at (please check your primary facility below):

- ☐ Broward Health Medical Center/Salah Foundation Children's Hospital
- ☐ Broward Health North
- ☐ Broward Health Imperial Point
- ☐ Broward Health Coral Springs
- ☐ Broward Community Health Services

I hereby request authorization to sponsor ________________________________ (the "Observer") for purposes of clinical observation.

The Sponsoring Physician and Observer understand that:

1. The Sponsoring Physician will be solely responsible for providing the Observer with the opportunity to observe clinical practices within the limitations of Sponsoring Physician's specialty and area of clinical expertise.

2. The Observer is allowed to observe only those patients of the Sponsoring Physician and only in the presence of said Sponsoring Physician.

3. The Observer is not permitted to make any comments or recordings in the official medical record of any patient, nor is the Observer to order, in writing or verbally, any treatment, test, procedure, medication, etc., nor to render any diagnostic or clinical opinions.

4. In no case should confidential information be conveyed to individuals outside the organization, including family or associates, or even other facility employees or other health care team members who do not need the information in performing their job duties.

5. Authorization may be withdrawn at any time, without cause. The relevant facility will notify the Sponsoring Physician and the Observer of the same.

The observer's period of observation with the physician will be from ____________________ to ________________________________

Sponsoring Physician's Signature: ________________________________

Printed Name: ________________________

Date: ________________________

Observer's Signature: ________________________

Printed Name: ________________________

Date: ________________________

Exhibit D

NORTH BROWARD HOSPITAL DISTRICT
d/b/a BROWARD HEALTH

OBSERVATIONAL EXPERIENCE ACKNOWLEDGEMENT

For and in consideration of the benefit provided the undersigned below ("Observer") in the form of an observational experience at the North Broward Hospital District d/b/a Broward Health, a special taxing district of the State of Florida ("Broward Health"), does hereby covenant, acknowledge and/or agree to do the following:

1. Limit experience solely to observation at the specific facilities and times approved by Broward Health. Under no circumstances will Observer participate in, provide or make any decisions relating to the evaluation, care or treatment of any Broward Health patient. All decisions relating to the evaluation, care and treatment of each individual patient will be made solely by Broward Health physicians, nurses or other authorized Broward Health personnel. This includes, but is not limited to, Observers not reviewing, writing in charts, or touching patients.

2. Abide by all policies, procedures, rules and regulations of Broward Health.

3. Present and conduct himself/herself in a manner that is professionally and ethically appropriate and that does not interfere with or create any risk of harm to Broward Health, its patients, employees, agents, or any persons on Broward Health premises.

4. Maintain the absolute confidentiality of all information (whether in oral, electronic or paper form) that Observer may have access to during his/her experience at Broward Health.

5. Reimburse and indemnify Broward Health for any damages or other injuries caused by Observer while participating in his/her observational experience at Broward Health.

6. Refrain from representing himself/herself as an agent, representative, or employee of Broward Health at any time. Observers should check in each day at the visitor's desk to obtain a visitor's pass, unless otherwise instructed. Visitor's pass should be prominently displayed at all times. Observers may not wear lab coats, jackets, or carry a stethoscope or any other medical evaluation equipment.

7. Assume all risks of, and be solely responsible for, any injury or illness, including medical care and treatment expenses, while participating in his/her observational experiences at Broward Health.

8. Vacate the premises if Broward Health determines that my observational experience is not in the best interest of its patients or personnel.

9. Assume the risk of possible exposure to hazards that could result in personal injury, illness, or death, among others.

10. I certify that I have received the Broward Health Code of Conduct, understand it represents mandatory policies of the organization, and agree to abide by it.

Dated this________ day of _________________,20______.

Observer's Signature	Parent's Signature (if observer is under age 18)
Printed Name:___________________________	Printed Name: ___________________________
Phone Number:__________________________	Phone Number:___________________________

Exhibit E

Observational Experience Influenza Vaccine Survey 20 -20

Applicant Name: ____________________

1. Did you receive the influenza vaccine during the 20__-20__ Influenza Season (October 1, 20__- March 31, 20__)?

   Yes _________ ***(If yes, continue to Question 2)*** No __________ (***If no, Skip to Question 5***)

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2. Month/Year Vaccine received ___________________
3. Please attach proof of flu vaccine
4. Please sign below

Thank you. This survey is Complete.

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5. Reason(s) for Declination of Flu Vaccine (for educational purposes)
   a. Medical Contraindication ______ (i.e. Guillain-Barre' Syndrome within 6 weeks after previous influenza vaccination or severe anaphylactic reaction to vaccine or vaccine component)
   b. Afraid Of Needles ______
   c. Religious Belief ______
   d. Afraid of Getting the Flu ______
   e. Choose Not to Consent ______
   f. Other Reason ______
6. Please sign below

Thank you. This survey is Complete.

Observer Signature ________________________________ **Date:** ______________________