



Tallahassee Orthopedic Clinic

Observer Application

Observers are responsible for securing a sponsor that will allow shadowing with them. TOC does not provide sponsors for observations & will not provide contact information for physicians.

Applications must be received at least 5 business days prior to requested start date.

APPLICANT INFORMATION					
Last Name		First Name		MI	
Street Address					
City		State		Zip	
Email				Phone	
Are you at least a Junior in High School?*			Are you at least 18 years of age?		
EMERGENCY CONTACT					
Name		Relationship		Phone	
CURRENT STATUS (Choose one)					
High School Student		Undergrad Student		Graduate Student	Medical Student
Medical Resident		Professional Trainee		Other (please list):	
If student, complete the following:					
Name of School or Program					
Major/Area of Study					
Current Year in School			Anticipated Graduation Term/Year		
SPONSOR & PLACEMENT INFORMATION					
Name of TOC Sponsor (Placement Supervisor)					
Requested Duration		Start Date		End Date	
OBSERVER AVAILABILITY (List hours available to observe)					
Mondays:		Tuesdays:			
Wednesdays:		Thursdays:			
Fridays:					
Area(s) of Observation		Outpatient Clinic		Surgery*	Other: _____
Briefly explain why you are interested in observing at TOC:					

*Applicants must be at least a junior in high school to apply for surgical observations. Please allow a minimum of 4 weeks for surgical observation applications to process, as these may require additional independent application(s) & approval from surgical facility(s).

Observer Signature

Parent/Guardian Signature (Required if Under 18)

TOC Sponsor Signature

Date



Tallahassee Orthopedic Clinic

TALLAHASSEE • MARIANNA • PERRY • BAINBRIDGE, GA

CONFIDENTIALITY DISCLAIMER FOR SHADOWING APPLICANTS

I understand and agree that all confidential information that is written or discussed at Tallahassee Orthopedic Clinic is highly confidential. **Confidential information** includes patient information, employee information, financial information, computer systems information and information proprietary to this organization and its owners. You may learn of or have access to some or all of this confidential information through the computer system, patient records, or through volunteer activities.

I understand that Violations of these obligations may subject you to legal consequences that could include but not be limited to prosecution and litigation. Further, by signing this Confidentiality Disclaimer, I understand that in the event Tallahassee Orthopedic Clinic incurs expenses, including any legal expenses, to address violations of this Confidentiality Disclaimer that I may be responsible for reimbursement of such expenses.

As a shadowing applicant, you agree with the following:

1. I will use confidential information only as needed to perform my legitimate duties as a volunteer.
2. I will only access information for which I have a need to know.
3. I will not in any way divulge, copy, release, sell, loan, review, alter, or destroy any confidential information except as properly authorized within the scope of my professional activities affiliated with this organization.
4. I will not misuse confidential information or carelessly care for confidential materials.
5. I will not discuss patient, company or employee confidential information outside the context of my daily responsibilities and I will not discuss such information in front of, or in hearing distance of those who do not have the need to know.
6. I will safeguard my access codes or any other authorizations that allow me access to confidential information.
7. I will report activities by any individual or entity that I suspect may compromise the integrity of confidential information.
8. I understand that my obligations under this agreement will continue after termination of my volunteer work.
9. All medical records shall be the property of the Company.

By signing this agreement, I attest that I have read and understand the above information and agree to adhere to this organization's confidentiality policies.

PRINT NAME HERE

DEPARTMENT

SIGNATURE

DATE