

## Observation for Practicing Surgeons ONLY Instructions

- On-line application **MUST** be completed at the following link. Choose **Robotic Shadowing** as your program <https://www.volgistics.com/ex/portal.dll/ap?ap=1986761365>

In addition to the on-line application, you must also provide the following compliance documents:

- Copy of Photo ID (*such as: driver's license, employee ID or passport*)
- Resume
- Fully completed vaccination-titer form (**page 2**)
  - **MUST BE** signed by a healthcare provider
  - A **TST within the last 3 months** or **TB blood test within 12 months**
- TB Screening Questionnaire (**page 3**)
- Signed Observation Agreement (**page 4**)
- COVID-19 Risk Attestation (**pages 5-7**)
- Proof of Flu Vaccine (*during flu season*)
- Photo for Badge
  - Unacceptable forms
    - Electronically signed forms
    - Missing information on required health items
    - Not signed by healthcare provider

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All required documents must be downloaded, completed, and returned via e-mail to the Office of Academic Affairs at [BSV-AcademicAffairs@bshsi.org](mailto:BSV-AcademicAffairs@bshsi.org).

**You will NOT be allowed to be on-site without completing the required compliance documents, obtaining approval, and receiving an approval badge from the Office of Academic Affairs.**

You will receive an approval badge that must be worn while on-site at all times during your observation/shadowing experience.

**Your badge will be delivered to the facility's OR selected on your application prior to your observation date.**

## Bon Secours Richmond/Hampton Roads Vaccination-Titer Form

**Requirements for Students/Observers (Please Print):**

Student Name: \_\_\_\_\_ School: \_\_\_\_\_

Email: \_\_\_\_\_

Address: \_\_\_\_\_

Bon Secours Preceptor: (printed name): \_\_\_\_\_ Date: \_\_\_\_\_

Vaccines:  MMR #1 \_\_\_\_\_

List date given  MMR #2 \_\_\_\_\_

\*Hepatitis B Series #1 \_\_\_\_\_  N/A

Hepatitis B Series #2 \_\_\_\_\_  N/A

Hepatitis B Series #3 \_\_\_\_\_  N/A

Varivax #1: \_\_\_\_\_

Varivax #2: \_\_\_\_\_

Tdap: \_\_\_\_\_

Flu Vaccine: \_\_\_\_\_

Other screening test:  \*\*TST 1<sup>st</sup> \_\_\_\_\_ Result: \_\_\_\_\_ TST 2<sup>nd</sup> \_\_\_\_\_ Result \_\_\_\_\_  N/A

\*\*\* CXR \_\_\_\_\_ Result: \_\_\_\_\_  N/A

\*\* TSPOT: \_\_\_\_\_ Result: \_\_\_\_\_  N/A

1 TST within last 3 months  
Plus Annual TB form

**Titers:**  Rubella: Date: \_\_\_\_\_ Result: \_\_\_\_\_

List date titer drawn  Rubeola: Date: \_\_\_\_\_ Result: \_\_\_\_\_

Mumps: Date: \_\_\_\_\_ Result: \_\_\_\_\_

Varicella: Date: \_\_\_\_\_ Result: \_\_\_\_\_

Hepatitis B: Date: \_\_\_\_\_ Result: \_\_\_\_\_  N/A

\_\_\_\_\_  
Healthcare Provider Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
E-mail/phone number

**Key:**  
\*\* TB screening requires two tests unless the worker receives a TSPOT blood test. Shadowing students only need one within 3 months before start date.  
\*\*\* Chest x-ray is only necessary if the TB test or TSPOT are found to be positive.



# employee health

Employee Wellness Services: EAP, Wellness, Employee Health

**TB Screening Questionnaire**  
**IF YOU ANSWER YES TO ANY QUESTIONS,**  
**YOU MUST REPORT TO EMPLOYEE WELLNESS IN PERSON**

PRINT Student Name	Facility placement will be in	Full Social Security #			
School	Phone #				
<b>TB History</b>					
	<b>NO</b>	<b>YES</b>		<b>NO</b>	<b>YES</b>
Previous positive TB Skin/Blood Test?			Are you being treated for a serious medical condition?		
If yes, were you treated with medication?			Are you taking steroids or chemotherapy?		
If yes, what is the date of your last chest x-ray?					
<b>In the last 12 months, have any of the following occurred?</b>					
	<b>NO</b>	<b>YES</b>		<b>NO</b>	<b>YES</b>
Chronic cough (3 weeks or longer)?			Coughing up blood?		
Chronic fatigue (tiredness)?			Persistent night sweats? (not hormonal)		
Fever, chills?			Unexplained weight loss?		
In the past year, have you been to a foreign country?			In the past year up to present have you been in close contact with a person, without you wearing PPE, who has been diagnosed with active TB?		
If yes, where? _____			If yes, where: at work: _____		
Length of stay: _____			name of patient: _____		
Date returned to the US: _____			in your home: _____		
Purpose of trip? Visit family: _____			in the community: _____		
vacation: _____			Other: _____		
mission: _____					
other: _____					
If you answered yes to any question above, please explain and report in person to Employee Wellness.					
Have you had a job title change in the last 12 months? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please print your current job title:					

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 EWS Reviewer: \_\_\_\_\_ Date: \_\_\_\_\_  
 Follow-up Recommendations:

## Observation Agreement

I acknowledge and understand that I may have access to proprietary or other confidential business information belonging to Bon Secours Richmond (BSR) or Bon Secours Hampton Roads (BSHR). In addition, I acknowledge and understand that I may have access to confidential information regarding Bon Secours BSR & BSHR employees, patients, and patient care. Therefore, except as required by my employer or by law, I agree that I will not:

- A. Disclose to any other person, or allow any other person access to, any information related to Bon Secours which is proprietary or confidential and/or pertains to employees, patients or patient care.

“Disclosure of information” includes, but is not limited to, verbal discussions, FAX transmissions, providing hard copies, electronic message transmission, taking pictures of data, voice mail communication, written documentation, “loaning” computer access codes, copying sensitive or confidential information to unauthorized, unprotected electronic devices and/or other electronic transmission or sharing of data.

I understand that Bon Secours, its patients, staff, or others may suffer irreparable harm by disclosure of proprietary or confidential information and that Bon Secours may seek legal remedies available to it should such disclosure occur. Further, I understand that violations of this agreement. I understand that this statement is binding both during my clinical experience and thereafter.

In exchange for authorization to participate in an observational experience at Bon Secours, I agree to:

- Provide confirmation that I have had a tuberculosis (TB) screening within the past 3 months and am free of TB to the best of my knowledge
- Read and follow the orientation instructions and any other materials provided by Bon Secours related to this experience
- Reschedule my observation experience if I have been exposed to any infectious conditions in the immediate 48-hours prior to the observation experience or if I am not feeling well the day of the experience
- Not touch patients or participate in any procedures or patient care/treatment activities
- Maintain a distance of six feet from patients when possible to reduce the risk of possible airborne infection transmission
- Remain with the designated healthcare professional at all times when in patient care/treatment areas and not enter rooms or offices without permission
- Keep patient personal and private information confidential (i.e, what I hear and see there will stay there)
- Not share any patient information verbally, in writing, through social media, or in any other format with others
- Not take pictures or videos of patients, staff, visitors, or others without written authorization in any patient care or treatment areas
- Comply with the rules and procedures of Bon Secours as instructed during this observation experience
- Not remove any forms, documents, equipment, materials, resources, or other items from Bon Secours without permission

Understanding that the nature of a healthcare environment can potentially expose me to emotional and physical trauma, infections, such as the flu, and dangerous equipment, I acknowledge that I am participating in this observation experience at my own risk and that Bon Secours is not financially or legally responsible for any injury or illness incurred as a result of this observation experience. Therefore, in consideration of the benefits to be derived from this experience, any and all claims against Bon Secours or any person working under its direction are hereby expressly waived.

Signature of Observer: \_\_\_\_\_

Date: \_\_\_\_\_

## ATTESTATION OF ADDITIONAL BSMH CLINICAL EXPERIENCE REQUIREMENTS DUE TO COVID-19 PANDEMIC, AND WAIVER AND RELEASE

### To be completed by all Students and Faculty

All students and school faculty instructors who seek to participate in a clinical experience at a Bon Secours Mercy Health, Inc. (“**BSMH**”) facility (“**Student(s)**” or “**Faculty**,” as applicable) shall be required to follow the applicable COVID-19 policies and procedures in place for associates and staff in the applicable BSMH market where the experience is scheduled to occur. Students and Faculty acknowledge that such policies and procedures may change over time as determined by the BSMH market, and current policies and procedures will be communicated by appropriate BSMH leadership to the Student and Faculty or to his/her educational institution (“**School**”).

Under current policies in place as of January 18, 2021:

- To be eligible for a clinical experience, the Student must have been in the United States for the 14 days preceding the start of his/her clinical experience. If a Student has been outside the United States during that time, the Student must remain in quarantine in the United States for the 14 days prior to being eligible to start a clinical rotation or other in-person activity at a BSMH facility. The same requirements apply to any Faculty who is onsite at a BSMH facility.
- Upon entering a BSMH facility, the Student/Faculty will be screened for symptoms of COVID-19, which may include: a temperature check; and an oral attestation that the Student/Faculty has absence of fever and symptoms of COVID-19, absence of a diagnosis of SARS-CoV-2 infection in the prior 10 days, and confirm they have not been exposed to others with SARS-CoV-2 infection during the prior 14 days. A Student/Faculty is not eligible to attend any clinical experience if he/she has any of the following symptoms (or has had any of the following symptoms in the preceding 14 days): a fever > 100 degrees, new onset shortness of breath, or difficulty breathing.
- The Student/Faculty acknowledges he/she has been properly trained in the don/doff procedure for personal protective equipment (“**PPE**”) and has been fit-tested for the appropriate N95 respirator by his/her School prior to caring for COVID-19 positive patients. The Student/Faculty is aware and acknowledges that although BSMH has developed policies and procedures to minimize the risk of exposure to COVID-19, the risk of exposure to, and possibly contracting, COVID-19 during a clinical experience at a BSMH facility remains.

To help protect its patients, visitors, students, associates and staff, BSMH also is requiring each Student and Faculty to agree to all the following statements as a condition of participating in any clinical experience within a BSMH facility, including possible learning opportunities on a COVID-19 designated unit. Please review and initial your acceptance of each statement below:

\_\_\_\_\_ I understand and agree that working in a BSMH facility, including any clinical experience on a COVID-19 designated unit in that facility, may increase my risk for contracting an infectious disease, such as COVID-19. I will be provided CDC-recommended PPE in compliance with CDC guidelines and BSMH policies. Such policies and procedures may change over time as determined by BSMH. I agree that, while on the BSMH-facility campus, I will adhere to all precautions required by the facility (which may include, but are not limited to: wearing masks, gloves and other PPE; social distancing; handwashing; and

## BON SECOURS MERCY HEALTH

cleaning and disinfection procedures). I agree that if I fail to follow any of these precautions, I may be removed from the facility and may not be eligible to return.

\_\_\_\_\_ I understand and agree that I may be subject to a COVID-19 screening each time I enter a BSMH facility. Even if I am not screened upon entry, I understand that I have an affirmative obligation to report the following to BSMH upon entering a BSMH facility for a clinical experience and **before** I engage in any such experience with a health care provider or patient at that facility: (i) my exposure to COVID-19, including any contact in the preceding 14 days with an individual known to have COVID-19 and any incident within a BSMH facility during which I believe I may have been exposed (e.g. PPE failure); (ii) any signs or symptoms of COVID-19. Further, I agree that I will immediately report to BSMH any positive COVID-19 test and I will abstain from attending or supervising (as applicable) any clinical experience at a BSMH facility following a positive COVID-19 test until both 10 days have passed from the positive test result and all symptoms have resolved, or as otherwise specified by current CDC guidelines. In addition, I understand that, upon request of a BSMH facility, I may be required to submit to a COVID-19 test to participate in the clinical experience (e.g. to return after confirmed COVID-19 test or suspected exposure).

\_\_\_\_\_ In consideration for my eligibility to participate or supervise (as applicable) in a clinical experience at a BSMH facility, which may include experience on a COVID-19 designated unit, I agree, on behalf of myself and any heirs, executors and administrators, to: (i) release BSMH, its affiliates, and their respective insurers, officers, directors, instructors, agents, employees, and volunteers (“**BSMH Parties**”) from all claim, liability, loss, injury, and damage of any kind that may arise, directly or indirectly, from my exposure to, or possible contraction of, COVID-19 or related illness or disease during my clinical experience at one or more BSMH facilities (“**Claim**”); and (ii) waive any and all such Claims I have or that I may have against BSMH Parties. This release and waiver shall be as broad and inclusive as is permitted by applicable law. If any portion is held invalid, the remainder shall continue in full force and effect.

\_\_\_\_\_ I understand and agree that each BSMH facility with whom I may have (or may supervise, as applicable) a clinical experience reserves the right to adjust, reschedule, or terminate that clinical experience at that facility if: (i) sufficient patient care resources (e.g., PPE) are unavailable or are otherwise scarce at that facility; (ii) there is a spike or other concerning trend in COVID-19 cases at that facility or in the surrounding BSMH market; or (iii) otherwise in accordance with that BSMH facility’s policies and procedures. Also, I understand that if the assigned Faculty supervising the clinical experience does not pass screening or they are unable to supervise the clinical experience, the clinical will be canceled until an alternate Faculty member that meets BSMH requirements can arrive or until the next scheduled clinical day.

By signing, below, I confirm that I have read this Form or have had it effectively communicated to me, and that any questions I may have had about this Form have been asked and answered to my satisfaction. **I further confirm that I accept all terms of this Form, that I am at least 18 years old, that I am a Student or Faculty as indicated below, and that I am signing this Form voluntarily.**

**I am:**

- a Student
- Faculty

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

# BON SECOURS MERCY HEALTH

## ACKNOWLEDGEMENT OF SCHOOL

School agrees that the Student and Faculty are presenting to the BSMH facility for a clinical experience as a current, enrolled Student and Faculty of the School, and School acknowledges the additional clinical experience requirements imposed upon the Student and Faculty as described herein. School agrees to keep a copy of this Attestation with its records, and to ensure that it has a fully executed copy of this Attestation prior to finalizing the clinical experience of the Student, above, at a BSMH entity.

Signature of School Representative: *[Not Applicable]* Date *[N/A]*

Name of School Representative: *[Not Applicable]*

Name of School: *[Not Applicable]*

**Bon Secours EMERGENCY CODE TERMINOLOGY STANDARDIZATION**

<b>Code Type</b>	<b>Current State</b>	<b>Approved Code</b>
<b>Medical Alert</b>		
Adult Medical Emergency	Blue	Medical Alert + Code Blue Adult + Location
Pediatric Medical Emergency	99/Blue	Medical Alert + Pediatric Code Blue Pediatric + location
OB Medical Emergency	Obert	Medical Alert + Code Obert + location
Acute Stroke	S	Medical Alert + Code Stroke + location
Visitor Staff Medical Emergency	Orange/Green	Medical Alert + Visitor Staff Medical Emergency + location
Rapid Response Team	Rapid Response	Medical Alert + Adult Rapid Response + location
Rapid Response Team	Rapid Response	Medical Alert + Pediatric Rapid Response Pediatric + location
Delivery outside of L&D	White	Medical Alert + Code Delivery + location
STEMI	STEMI	Medical Alert + Code STEMI + location
Sepsis	N/A	Medical Alert + Code Sepsis + location
Malignant Hyperthermia	Hot/None	Medical Alert + Code Hot + location
Asphyxia	Ice	Medical Alert + Code Ice + location
<b>Security Alert</b>		
Active Shooter	None/Active Shooter	Security Alert + Active Shooter + location
ED Lockdown	None	Security Alert + ED Lockdown
Hospital Lockdown	Lockdown/Gold	Security Alert + Hospital Lockdown
Bomb Threat	B/Black	Security Alert + Code Black + location
Combative Patient/Visitor	Atlas/Grey	Security Alert + Code Atlas
Abduction/Missing Patient	A/L/Purple	Security Alert + Missing Adult/Child + descriptor
Abduction/Missing Infant	Amber/Pink	Security Alert + Missing Infant + descriptor
<b>Facility Alert</b>		
Fire	Red	Code Red + fire alarm + location
Disaster/Mass Casualty	D/Silver	Facility Alert + External Mass Casualty
Evacuation	E/None	Facility Alert + Evacuation +type + location
Hazmat	H/Yellow	Facility Alert + Hazmat + location
Utility Alert	U/Orange	Facility Alert + Utility Failure + descriptor + location
Technology Downtime		Downtime + Technology impacted
<b>Weather Alerts</b>		
Snow Plan	White/None	Severe Weather Alert + descriptor
Sever Weather	W/Brown	Severe Weather Alert + descriptor