

PURPOSE

An Observership is an unpaid experience in which a visiting Practitioner (physician, dentist, oral surgeon, or podiatrist) shadows a member of the Medical Staff (the Host Practitioner) in a clinical setting. It may be an opportunity to learn firsthand recent innovations in surgery and medicine, but is not a hands-on clinical experience and is subject to the AHS Job Shadowing Policy (<http://www.albertahealthservices.ca/Policies/clp-ahs-pol-job-shadowing.pdf>). The Observer is to be strictly supervised at all times, shall not be granted independent access to AHS facilities and resources, shall not provide any services, and shall not be left unattended at any time. As well, all observers must comply with patient safety and Workplace Health and Safety (WHS) requirements.

PROCESS

The Observer is required to attach the following to the Enrollment Form for review by the Zone Clinical Department (ZCD):

- ☐ AHS Confidentiality & User Agreement presented at the end of the online AHS Information & Privacy and IT Security & Awareness (<https://www.albertahealthservices.ca/info/Page3962.aspx>).
- ☐ Proof of immunization (specifically a vaccination record or serologic report for Rubella).
- ☐ AHS Security Check (criminal record check and vulnerable sector search) - *for experiences over 5 business days*

The Zone Clinical Department will review and email the approved Enrollment Form and supporting documents to CAL.MedicalEducationOffice@ahs.ca. Medical Affairs will verify and distribute a confirmation memo.

All applicable fields must be completed for your request to be processed.

OBSERVER INFORMATION		
Last Name	First Name	Middle Name
Known As	Phone Number	Email Address

*Personal information contained in this document is governed by the Health Information Act of Alberta. The information is collected and used for the purposes of identifying and regulating medical staff at Alberta Health Services and for managing the health system (s. 27). The information will only be disclosed to other agencies or for other purposes with the applicant's consent or to a health professional body for the purposes of investigation, discipline, practice review, or inspection of the medical staff member or in accordance with other legislation (s. 37). **Learn more about the Collection & Use of Medical Staff Personal Information [here](#).***

OBSERVERSHIP INFORMATION		
Host Practitioner Name		Host Practitioner Phone Number
		Host Practitioner Email Address
Clinical Department		Clinical Section
		Clinical Site/Service/Program
Anticipated Start Date	Anticipated End Date	Purpose of Observational Experience

OBSERVER CONSENT		
<p>By signing below, the Observer states that he/she understands the detailed content of the Consent and Confidentiality Agreement on page 2 of this Enrollment form and the Host Practitioner and Zone Clinical Department have reviewed it with him/her.</p> <p>As well, the Observer understands this position is for 'shadowing' only. While in AHS facilities, you are not permitted to undertake any direct patient care including: history taking, physical examinations, entries into Health Records or access to Patient Care Information Systems.</p>		
PRINTED NAME	SIGNATURE	DATE

CONSENT AND CONFIDENTIALITY *(duplicate this page for multiple host practitioners)*

AHS supports opportunities for external Practitioners to observe a host for a defined period. As the Canadian healthcare environment may be unfamiliar, the Host Practitioner and their Zone Clinical Department must ensure that Observer is aware of and complies with the policies, directives and practices (together referred to as “rules”), such as confidentiality and safety.

Please read the following statements that are to be adhered to by the Host Practitioner.

- I would like to participate and host an Observer at AHS.
- I agree that it is my responsibility that the Observer complies with all policies including confidentiality. I will explain to the Observer that AHS has a legal and ethical responsibility to safeguard the privacy of all patients/residents/clients and to protect the confidentiality of their personal information. My Observer agrees to abide by the AHS policies and procedures concerning confidentiality and release of information.
- I understand that all personal and health information the Observer is privy to is private and confidential. The Observer agrees not to discuss with anyone any individual’s identifying personal or health information that they may come into contact with while participating.
- I understand that I may be held responsible for any improper conduct of the Observer, including but not limited to any breach of privacy or confidentiality.
- I agree that I will not hold AHS liable or responsible for injury suffered to the Observer while participating howsoever caused.
- I agree to indemnify AHS for any loss that it may sustain as a result of the Observer’s participation.
- I understand that in order to participate in the program, the Observer is required to have the Rubella (German measles) and COVID-19 vaccines. It is also strongly recommended for the Observer to have the following vaccinations and/or immunizations: Pertussis (Whooping Cough), Tetanus + Diphtheria, Measles, Mumps, Polio, Hepatitis B, Varicella (Chickenpox), Seasonal Influenza and Tuberculosis skin test.
- I understand that for observational experiences of duration greater than one (1) week, the Observer shall also be required to provide a criminal record check and vulnerable sector search.

HOST PRACTITIONER CONSENT

By signing below, the Host Practitioner states they have:

- Reviewed the content of this Consent and Confidentiality Agreement with the Observer.
- Determined that the clinical area is a suitable environment for participation.
- Discussed any clinical area specific restrictions regarding participation directly with the Observer.

HOST PRACTITIONER PRINTED NAME

SIGNATURE

DATE

ZONE CLINICAL DEPARTMENT APPROVAL

By signing below, the manager states they have approved the request based on:

- potential risks and AHS operational needs and constraints;
- environmental factors including workplace health and safety issues; and
- impact on and willingness of AHS representatives (employees, medical staff, trainees, and others) to participate in the experience.

DEPARTMENT MANAGER PRINTED NAME

SIGNATURE

DATE

Please notify CAL.MedicalEducationOffice@ahs.ca of any changes to the observership dates. Significant changes or changes to the Host Practitioner may require a new Enrollment Form.