OU Health Observation Checklist

Medical Staff Support Services Department
920 Stanton L Young, WP 2410
Oklahoma City, OK 73104
Phone 405-271-3741
Fax 405-271-3602
Credentialing@ouhealth.com

A ***new request*** for an observation packet ***must be made each time*** a Practitioner is requesting an observation/shadow approval at OU Health. Contact the Medical Staff Support Services Department at 405-271-3741 and request an observation packet. These forms are subject to change at any time and we want to ensure you have the most current and up to date forms needed. Return completed documentation to fax or email listed above.

This information is required-no exceptions:

1. ____Completed Physician/Resident Observer-Shadow Information Form (2 pages)
2. ____Completed Physician/Resident Observer-Shadow Permission Form signed by the Sponsoring Physician and the Physician/Resident Observer
3. ____Signed/dated Confidentiality and Security Agreement Form
4. ____ Signed Attestation, Authorization, and Release form
5. ____COVID Vaccination Documentation
6. ____Current TB documentation (within the previous 12 months) Documentation must include: Date test read, Name/title of qualified person reading test, Lot number of test administered, and Results. Any positive result must be followed up with chest x-ray indicating no current infection.
7. ____Current Influenza immunization documentation (from the current/most recent flu season)
8. ____Copy of a Government Issued Photo ID (example: Passport, Driver's License)
9. ____If not a US citizen, in addition to Government Issued Photo ID submit a copy of Visa or Electronic System for Travel Authorization Application Approval (Visa Waiver Program), or for Canadian visitors a copy of the I-94 form.

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Physician/Resident Observer-Shadow Information Form

This form is for Physicians only requesting to observe at OU Health and must be filled out in its entirety with a signature/date the bottom of the second page. If you are not a Physician, please contact our office as you may need to go through a different department for your request.

Name: ____________________ ____________________ ____________________
(First) (Middle) (Last)

Contact Phone: ____

Email Address: ____

SSN or Passport Number: ____

United States Citizen? (Yes or No) ____________________

Medical License # ____________________ State or Country of Licensure ____________________

Discipline/Clinical Service Requested: ____

Attending Physician to be Observed: ____

Attending Physician Contact Number: ____

Date Range of Observation/Shadow: From-____________________ To-____________________

Reason for Observation/Shadow ____

Have you applied or will you be applying for Medical Staff Membership and Privileges?____________________

Revised 12/2022

Attestation of Immunization

(Initial next each appropriate response)

________ I attest that I have received immunization for measles, mumps, rubella, varicella, and tdap.

________ I have **received** the Hepatitis B Vaccination

________ I have **declined** the Hepatitis B Vaccination

Date of most recent Influenza Vaccination: __________________

Proof of Influenza documentation from the current flu season must accompany request.

Date of Tuberculosis testing within previous 12 months: ___________________Result:___________________

Proof of current TB including results within the previous 12 months must accompany request; if results are positive please also provide copy of Chest X-ray indicating no current infection and answer the risk assessment below.

Have you previously had a positive TB test (Tb Skin Test or IGRA(blood test) Yes No
Date of previous positive:____________________

Have you been treated for Latent or Active TB in the past? Yes No

If yes, dates of treatment:____________ Medication received:___________________
Did you complete prescribed Course? Yes No

Individual Risk Assessment: Please answer the following questions:
1)Since your last TB screening, have you had a temporary or permanent residence of ≥ 1 month in a country with a high TB rate? (Any country other than the United States, Canada, Australia,New Zealand, and those in Northern or Western Europe)
Yes No

2) Do you have any medical risk factors for progression from latent (dormant) TB infection to active TB disease, if infected?

- HIV Infection (the virus that causes AIDS) Yes No
- Receipt of an organ transplant, Yes No
- Treatment with a TNF-alpha antagonist (e.g. infliximab, etanercept, or other),
- Chronic steroids (equivalent of prednisone ≥ 15 mgday for ≥ 1 month),
- Specialized treatment for rheumatoid arthritis or Crohn's disease or other immunosuppressive medications

Yes No

3) Have you been in close contact with someone who has had infectious TB disease since your last TB test? Yes No

TB sign & Symptoms Screening Assessment. Do you currently have any of the following signs or symptoms of tuberculosis disease?

Cough lasting 3 weeks or longer Coughing up blood Night sweats Unexplained weight loss Fever /chills for no known reason

Fatigue

None of the above

Physician/Resident Observer Signature:_____________________________________Date: _________________

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Physician/Resident Observer-Shadow Permission Form

Physician Observation/Shadow Program Information

Please note that it is the sole responsibility of the practitioner applying for the physician observation/shadow program to make arrangements to observe/shadow a credentialed OU Health Physician. OU Health will not facilitate the arrangements between the practitioner and the Physician.

Please fill out the following contact information:

Physician Observer/Shadow Name: ____

Physician Observer/Shadow Cell Phone/Pager:___________________________________

Physician Observer/Shadow E-mail Address: ____________________________________

Date(s) of Observation/Shadow: From: ________________To: __________________

SPONSORING PHYSICIAN INFORMATION

Sponsoring Physician to be observed: _______________________________________

Sponsoring Physician Department: ____

Sponsoring Physician Office Number: ____

Sponsoring Physician Cell Phone/Pager: _____________________________________

Sponsoring Physician E-mail Address: _______________________________________

Sponsoring Physician Printed Name: ____

Sponsoring Physician Signature: ___________________________**Date:** ____________

AUTHORIZATION FOR RELEASE

Physician Observer/Shadow Medical Release

In consideration of acceptance of the Physician Observer/Shadow to participate in the Physician Observation/Shadow Program, I hereby waive any and all claims for myself and my heirs against OU Health and all sponsors of the program, for injury or illness which may directly or indirectly result in my participation. I further agree to save and hold said parties harmless and agree to indemnify each of said persons against all liability for any loss, cost, injury or damage to persons or property, which may arise by virtue of engaging in the Physician Observation/Shadow Program. I am in proper physical condition to participate in this program.
I understand that while I'm in attendance in the Physician Observation/Shadow Program, I may be photographed and/or filmed. I grant OU Health the exclusive right to tape, broadcast, use, sell or photograph and all other electronic or mechanical reproduction in connection with the Physician Observation/Shadow Program, of myself alone or with other persons, together with alterations or edited version of the foregoing.

Physician Observer/Shadow Name: ____

Medical Institution/School: ____

Physician Observer/Shadow Signature: ________________________________

If this release is not signed, you will not be allowed to participate in the Physician Observation/Shadow Program.

TO BE COMPLETED BY MEDICAL STAFF/CREDENTIALING DEPT.

______Government Issued ID Copied
______Non-US Citizen documentation for entry into the US
______Observation/Shadow Packet Completed
______Attest to Immunizations Completed
______Attending Physician Permission Form Completed
______ COVID Documentation
______ TB Documentation
______ Influenza Documentation
______ ID Badge Issued w/ date range of Approval
______ Copy of ID Badge once printed
______ Attending Physician notified of approval: Date notified:______________
______ Physician Observer/Shadow notified of approval: Date notified:___________
Comments:

Credentialing Coordinator Signature: ____________________ Date: ______________
Printed Name: ____

Revised 12/2022

Provider Confidentiality and Security Agreement

Note: this form to be used for non-employed physicians, providers and their employed staff.

I understand that OU Health and its affiliated facilities and entities (collectively, "OUH" or the "Company") manages health information as part of its mission to treat patients. Further, I understand that the Company has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their patients' health information. Additionally, the Company must assure the confidentiality of its human resources, payroll, fiscal, research, internal reporting, strategic planning information, credentialing, intellectual property, or any information that contains Social Security numbers, health insurance claim numbers, passwords, PINs, encryption keys, credit card or other financial account numbers (collectively, with patient identifiable health information, "Confidential Information").

In the course of my affiliation or employment with the Company, I understand that I may come into the possession of this type of Confidential Information. I will access and use this information only when it is necessary to perform my job related duties in accordance with the Company's Privacy and Security Policies, which are available on the Company intranet (on the Security Page) and the Internet (under Ethics & Compliance). I further understand that I must sign and comply with this Agreement in order to obtain authorization for access to Confidential Information or Company provided systems.

General Rules

1. I will act in accordance with the Company's Code of Conduct at all times during my relationship with the Company.
2. I understand that I should have no expectation of privacy when using Company information systems. The Company may log, access, review, and otherwise utilize information stored on or passing through its systems, including email, in order to manage systems and enforce security.
3. I understand that violation of this Agreement may result in disciplinary action, up to and including termination of employment, suspension, and loss of privileges, and/or termination of authorization to work within the Company, in accordance with the Company's policies.
4. I have no intention of varying the volume or value of referrals I make to the Company in exchange for Internet access service or for access to any other Company information.
5. I have not agreed, in writing or otherwise, to accept Internet access in exchange for the referral to the Company of any patients or other business.
6. I understand that the Company may decide at any time without notice to no longer provide access to any systems to physicians on the medical staff unless other contracts or agreements state otherwise. I understand that if I am no longer a member of the OUH medical staff, I may no longer use OUH's equipment to access the Internet.

Protecting Confidential Information

7. I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know it. I will not take media or documents containing Confidential Information home with me unless specifically authorized to do so as part of my job.
8. I will not publish or disclose any Confidential Information to others using personal email, or to any Internet sites, or through Internet blogs or sites such as Facebook or Twitter. I will only use such communication methods when explicitly authorized to do so in support of Company business and within the permitted uses of Confidential Information as governed by regulations such as HIPAA.
9. I will not in any way divulge, copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized. I will only reuse or destroy media in accordance with Company Information Security Standards.
10. In the course of treating patients, I may need to orally communicate health information to or about patients. While I understand that my first priority is treating patients, I will take reasonable safeguards to protect conversations from unauthorized listeners. Such safeguards include, but are not limited to: lowering my voice or using private rooms or areas where available.
11. I will not make any unauthorized transmissions, inquiries, modifications, or purging of Confidential Information.
12. I will secure electronic communications by transmitting Confidential Information only to authorized entities, in accordance with industry-approved security standards, such as encryption.

Following Appropriate Access

13. I will only access or use systems or devices I am officially authorized to access, will only do so for the purpose of delivery of medical services at OUH facilities, and will not demonstrate the operation or function of systems or devices to unauthorized individuals.
14. I will only access software systems to review patient records or Company information when I have a business need to know, as well as any necessary consent. By accessing a patient's record or Company information, I am affirmatively representing to the Company at the time of each access that I have the requisite business need to know and appropriate consent, and the Company may rely on that representation in granting such access to me.

15. I will insure that only appropriate personnel in my office, who have been through a screening process, will access the Company software systems and Confidential Information and I will annually train such personnel on issues related to patient confidentiality and access.
16. I will accept full responsibility for the actions of my employees who may access the Company software systems and Confidential Information.
17. I agree that if I, or my staff, stores Confidential Information on non-Company media or devices (*e.g.*, PDAs, laptops) or transmits data outside of the Company network, that the data then becomes my sole responsibility to protect according to federal regulations, and I will take full accountability for any data loss or breach.

Doing My Part – Personal Security

18. I understand that I will be assigned a unique identifier (*e.g.*, 3-4 User ID) to track my access and use of Confidential Information and that the identifier is associated with my personal data provided as part of the initial and/or periodic credentialing and/or employment verification processes.
19. I will ensure that members of my office staff use a unique identifier to access Confidential Information.
20. I will:
    a. Use only my officially assigned User-ID and password (and/or token).
    b. Use only approved licensed software.
    c. Use a device with virus protection software.
21. I will never:
    a. Disclose passwords, PINs, or access codes.
    b. Allow another individual to use my digital identity (e.g., 3-4 User ID) to access, modify, or delete data and/or use a computer system.
    c. Use tools or techniques to break/exploit security measures.
    d. Connect unauthorized systems or devices to the Company network.
22. I will practice good workstation security measures such as locking up external media when not in use, using screen savers with activated passwords appropriately, and positioning screens away from public view.
23. I will immediately notify my manager, OUH Information Security Official , OUH Director of Information Technology, or OUH help desk if:
    a. my password has been seen, disclosed, or otherwise compromised
    b. media with Confidential Information stored on it has been lost or stolen;
    c. I suspect a virus infection on any system;
    d. I am aware of any activity that violates this agreement, privacy and security policies; or
    e. I am aware of any other incident that could possibly have any adverse impact on Confidential Information or Company systems.

Upon Termination

24. I agree to notify the OUH IT Department within 24 hours, or the next business day, when members of my office staff are terminated, so that user accounts to Company systems are appropriately disabled in accordance with Company standards.
25. I agree that my obligations under this Agreement will continue after termination of my employment, expiration of my contract, or my relationship ceases with the Company.
26. Upon termination, I will immediately return any documents or media containing Confidential Information to the Company.
27. I understand that I have no right to any ownership interest in any Confidential Information accessed or created by me during and in the scope of my relationship with the Company.

By signing this document, I acknowledge that I have read this Agreement and I agree to comply with all the terms and conditions stated above.

Provider Signature		Date
Provider Printed Name		

AGREEMENT AND AUTHORIZATION

Authorization, Attestation and Release

General Acknowledgement: I understand and agree, as part of the credentialing application process for participation, membership and/or clinical privileges (hereinafter referred to as "Participation" at or with any OU Medicine Inc. d/b/a OU Health entity (hereinafter referred to as "Entity"), and any of the Entity's affiliates (hereinafter referred to as “OU Health”), I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and other criteria used by OU Health for determining initial and ongoing eligibility for participation. OU Health and its representatives, employees, and agent(s) acknowledge that the information obtained related to the application process will be held confidential to the extent permitted by law. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information does not guarantee: granting me clinical privileges; credentialing by payors; or employment by OU Health.

Interview and Agreement to Abide by OU Health Requirements: If requested, I consent to appear for an interview with representatives of the medical staff, OU Health administration, or governing body, if required or requested. As a medical staff member (as applicable), I pledge to provide continuous care for my patients and I agree that I will be bound by the medical staff bylaws and rules and regulations. I also agree to abide by all applicable OU Health policies, procedures and guidelines.

Authorization of Investigation Concerning Application for Participation: I authorize the following individuals including, without limitation, OU Health, its representatives, employees, and/or designated agent(s); the OU Health’s affiliated entities and their representatives, employees, and/or designated agents; and OU Health’s designated professional credentials verification organizations, or credentialing processing centers (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow OU Health and/or its Agent(s) to inspect all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation: I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to OU Health and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the OU Health. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization to Review Third-Party Data and Information: I do hereby grant to OU Health and/or its Agent(s) for the purpose of evaluating my credentials and qualifications, permission to gain access to inspect, and duplicate legally-releasable records related to my professional abilities and qualifications, professional ethics, education, and training currently on file at any and all acute care facilities, skilled nursing facilities, outpatient centers, and other institutional settings, and educational institutions with which I am now or have been affiliated, and any local, county, state, and federal medical trade association, accrediting organization, medical society, government entity or professional liability insurance carrier(s). I authorize OU Health and/or its Agent(s) to consult with employers, malpractice carriers, managed care companies, hospitals or other health care facilities, educational institutions, persons or entities who have been associated

with me and/or who may have information bearing on my competence and qualifications or that is otherwise relevant to the pending review.

Authorization of Third-Party Sources to Release Information Concerning Medical Professional Liability Insurance/Claims History: I authorize any past or current insurance carriers to release to the OU Health and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional liability coverage; including dates of coverage, amounts of coverage and any limitations in coverage. I specifically authorize my current and past professional liability carrier(s) to release to OU Health and/or its Agent(s) information relating to reports of any medical professional liability claims activity against me on record that have been made and/or are currently pending against me. I authorize the release of malpractice claims and insurance information to reinsurers, auditors, and other reviewers or agents of OU Health's captive professional liability program, APIC. The release of information shall be privileged and a protected disclosure to the extent allowed by Oklahoma law. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Release to Internal OU Health Departments: I do hereby grant to OU Health and/or their Agents permission to release information obtained in the course of peer review, claims handling, or risk management to internal departments and/or privileged committees when the disclosure is requested for the purpose of credentialing or to determine my ability and fitness to safely provide patient care.

Authorization of Release and Exchange of Ongoing Professional Performance Evaluations, Focused Professional Performance Evaluations and Disciplinary Information: I hereby further authorize any third party at which I currently have Participation or had participation and/or each third party's agents to release the results of Ongoing Professional Performance Evaluations and Focused Professional Performance Evaluations and any Disciplinary Information, as defined below, to OU Health and/or its Agent(s). I hereby further authorize the Agent(s) to release the results of Ongoing Professional Performance Evaluations and Focused Professional Performance Evaluations and any Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning: (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or e) in preparation.

Authorization and General Release for Background Investigation: I hereby authorize OU Health, and any of the OU Health's affiliated entities, and any employee or agents (including the contracted background investigation vendor) of any of them, to request and receive any information and records concerning me, including but not limited to consumer, criminal record history, driving, employment, military and educational data and reports, from any individuals, corporations, partnerships, associations, institutions, schools, governmental agencies and other entities, including my present and previous employers. I further release and discharge OU Health and any of the OU Health's affiliated entities, and any employee or agents (including the contracted background investigation vendor) of any of them, and all individuals and personnel, business, private or public entities of any kind, from any and all claims and liability arising out of any request(s) for a receipt of information or records pursuant to this authorization, or arising out of any compliance or attempted compliance with such request(s). I also authorize the procurement of an investigative consumer report and understand that it may contain information about my character and general reputation. I understand that I have the right to make written requests of the background investigation vendor for a complete and accurate disclosure of information concerning the nature and scope of the investigation.

Authorization and Release to Third Parties for Delegated and Telemedicine Credentialing. **This section is applicable to providers are being credentialed by a third party as part of a delegated or telemedicine credentialing process**. I

understand that as part of the delegated or telemedicine credentialing process, the information that I have provided to OU Health may be provided to another party ("Third Party") as part of that Third Party's credentialing process. The Third Party is relying on information that I previously submitted to OU Health. The Third Party may request information related to my current licensure, relevant training and/or experience, including all relevant educational experiences, clinical competence, health status, character, ethics, and other criteria used by the Third Party for determining initial and ongoing eligibility for participation. Such information includes, but is not limited to, my Oklahoma license number, my NPI, my date of birth, my social security number, my professional liability coverage, and the educational institutions I attended. The Third Party and its representatives, employees, and agent(s) acknowledge that the information obtained will be held confidential to the extent permitted by law. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee the Third Party will grant me clinical privileges. I authorize the following individuals including, without limitation, the Third Party, its representatives, employees, and/or designated agent(s); the Third Party's affiliated entities and their representatives, employees, and/or designated agents; and the Third Party's designated professional credentials verification organizations, or credentialing processing centers (collectively referred to as "Third Party Agents"), to investigate information, which may include both oral and written statements, records, and documents, concerning my application. I agree to allow the Third Party and/or its Third Party Agent(s) to inspect all records and documents relating to such an investigation. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization.

Obligation to Notify OU Health of Changes: I agree to notify OU Health immediately upon the termination, suspension, or denial of my malpractice insurance or medical license. I agree to notify OU Health of any Medicare and/or Medicaid sanctions. I also agree to notify OU Health immediately upon a hearing notice for, or a notification of, termination, suspension, or revocation of my staff privileges at any hospital or health facility. I agree to notify OU Health immediately upon a hearing notice for or notification of a Medical Board or other state agency investigation. I agree to abide by all rules, regulations, policies, procedures and guidelines applicable to OU Physicians practitioners and employees. I agree to notify OU Health of any other changes or events that affect my ability to practice.

Release from Liability: I extend absolute immunity to, and release from any and all liability OU Health, its Agent(s), Third Party and Third Party Agent(s) (as applicable), and any other third party for their acts performed in good faith in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I hereby release from liability all individuals and organizations that provide information described in this release of Information, for their acts performed in good faith.

I further agree not to sue OU Health, any Agent(s), Third Party and Third Party Agent(s) (as applicable), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such OU Health, Agent(s) or third party in connection with the credentialing process. If I violate this provision, I will pay for all the Released Parties attorney fees, court costs and expenses. The release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation and Release, all references to OU Health, its Agent(s), Third Party and Third Party Agent(s) (as applicable), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. OU Health, any Agent(s), Third Party and Third Party Agent(s) (as applicable), retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an OU Health, a member of an OU Health's medical or health care staff, or a participating provider of an OU Health. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the OU Health in accordance with the applicable bylaws, rules, and regulations, and requirements of the OU Health, or grounds for my termination of Participation at or with the OU Health. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

Certification: I certify that all information provided by me in my application is true, correct, and complete to the best of my knowledge and belief, and that the documented privileges being requested are accurate and I have the competencies necessary to perform those privileges, and that I will notify the OU Health and/or its Agent(s) within one (1) business day of any material changes to the information I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by OU Health, and must be submitted on-line or in writing, and must be dated and signed by me (may be a written or an electronic signature). I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to OU Health, Agent(s), Third Party (as applicable), or Third Party Agent(s) (as applicable).

I acknowledge that I have voluntarily provided all requested information, and I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

NAME (PLEASE PRINT OR TYPE): ______________________________

DATE: ______________________________

NPI: ______________________________

LAST 4 DIGITS OF SSN: ______________________________