



Saint Mary's Hospital
Trinity Health

Request for Observation in the Operating Room

Date:

Date of Birth: _____

Name:

Address: _____

Phone:

City: _____

E-Mail:

State: _____

Purpose of Request (be specific):

Zip: _____

Surgeon/Anesthesiologist to be observed: _____

Med. / PA / RN School: _____ Clinical Program: _____

Other School Affiliation: _____

Physician: _____

Date of Scheduled Observation: _____

Medical Clearance (PPD, Immunization, Physical (attached):

Include proof of FLU and COVID vaccines

Approved:

Denied:

Date:

Isha A. Emhoff, MD, MPH, FACS; Chair of Surgery

cc: Clinical Manager, OR



TRINITY HEALTH SITE VISIT CONFIDENTIALITY AGREEMENT

I understand that as part of a site visit at **St. Mary's Hospital (Waterbury)** I may come in contact with Confidential Information (as defined below). As such all site visitors are required to read, sign and abide by the terms and conditions of this Trinity Health Site Visit Confidentiality Agreement before participating in the site visit. This requirement includes site visitors who are participating via phone or electronic communication media.

Confidential Information shall mean all non-public information, whether verbal, visual or written, related to the Site, its patients, vendors, employees, and affiliates, including, but not limited to, information relating to:

- Patients' Protected Health Information (PHI) such as patient medical records, charts, diagnoses, treatment, demographic data, identifying numbers, insurance data, financial information, etc.
- Employment records; and
- Business records.

THEREFORE, in exchange for my participation in the site visit, I hereby acknowledge and agree to the following:

1. I understand that I have no right or privilege to access or view any Confidential Information and the Site has the right to deny me access to any and all information.
2. I understand and agree that I will only observe Confidential Information in the context of the site visit and will not record, capture or duplicate any or all information.
3. I agree not to disclose any Confidential Information obtained during the site visit and to use the Confidential Information only for my education regarding the functions demonstrated at the site visit.
4. I agree to immediately notify the Site of any use or disclosure of Confidential Information not permitted by this Agreement of which I become aware.
5. In the event that I take a guided tour of the Site, I agree not to stray outside of the area permitted by the Site's tour guide.

Date: _____

Visitor's Signature: _____

Visitor's Printed Name: _____

Visitor's Organization (Undergrad/Grad School): _____

Department of Occupational Health

IMMUNIZATION REQUIREMENTS FOR NEW EMPLOYEES, VOLUNTEERS, RESIDENTS AND STUDENTS

The following immunization requirements must be met prior to starting at Saint Mary's Hospital in order to protect you, our patients and the hospital staff. Full compliance with all immunization requirements as detailed below is necessary to complete the pre-employment/pre-service process. Please remember to bring **all** the required documentation to the Occupational Health Center on the day your pre-placement examination is scheduled. *Incomplete immunization records may delay your starting date.*

*****Immunizations may be obtained from your childhood records, pediatrician, high school, college, Obstetrician, and previous employment if you have been in the Health Care field.***

◆ Measles (Rubeola)

Anyone born after 1956 must show evidence of immunity by providing one of the following:

1. Proof of two MMRs (Measles, Mumps, Rubella) or two measles vaccines both received after 1969, and after one year of age: **OR**
2. Proof of laboratory documentation of immunity to measles (rubeola); **OR**
3. Proof of physician-diagnosed documentation of disease.

Date: 1st MMR _____, 2nd MMR _____
Titer result/date: Rubeola _____, Rubella _____, Mumps _____

◆ German Measles (Rubella)

Regardless of age, proof of immunity is necessary:

1. One MMR or rubella vaccination; **OR**
2. Laboratory documentation of immunity to rubella.

Date MMR or Rubella vaccine: _____

◆ Tuberculosis (TB) -- PPD Test

Required for all:

1. Current Negative QuantiFERON Result within one month.
2. If positive QuantiFERON, chest x-ray results and documentation of treatment must be provided. Date _____

◆ Hepatitis B

Depending on your exposure risk, Hepatitis B vaccine will be offered to you on the day of your pre-employment examination, at no charge. If you have previously received the vaccine and have demonstrated immunity, please bring written proof documenting your immune status.

◆ Hepatitis A

Depending on your exposure risk, Hepatitis A vaccine may be required. (mandatory for CDC & Dietary dept)

◆ Varicella (Chickenpox)

Depending on your Varicella history and the nature of your work, Varicella vaccine may be required. This is required for anyone working in a nursing care area with patients.

History of childhood disease: Y _____, N _____
Varicella Vaccine 1st _____, 2nd _____ or Positive Varicella Titer _____

** Tdap (Tetanus, Pertussis and Diphtheria Vaccine)

Highly recommended for those employees working in nursing care areas, especially those involved with infants and children.

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