Observation (“Shadowing”) Consent and Release Form

In consideration of the opportunity to observe the performance of medical personnel at McLaren Bay Region (“shadow”) as part of an observation program or interview, I agree to the following:

1. I understand that patients undergoing examination, procedure or treatment must consent to my presence.

2. I agree to maintain and protect the absolute confidentiality of the names of the patients and any other patient identifying information, as well as all information relating to the condition, diagnosis and treatment of any patient of which he/she becomes aware during the course of observation.

3. I understand that this is an observation only experience. I agree not to provide care of any kind to any patient or to write on any patient’s medical record.

4. I understand that McLaren Bay Region will not assume or provide any type of insurance coverage, including malpractice insurance coverage, for me while I am on hospital premises.

5. I will wear a hospital identification badge at all times while in the hospital identifying me as an observer. I will surrender the badge to the Medical Education office when the experience is completed.

6. I understand that I will, at all times, remain in the presence of the physician whom I am shadowing. I will leave the patient care areas when the shadowing physician leaves.

7. I acknowledge that no assurance or representation concerning my health or safety during the period of my observation have been made to me. I understand that numerous risks to health and safety may be present in a hospital, including but not limited to exposure to infectious agents, and I voluntarily assume all risks associated with my presence in the hospital as an observer.

8. I understand that McLaren Bay Region reserves the right to terminate the observation experience at any time.

I hereby release McLaren Bay Region, its medical staff, physicians, directors, officers, employees, agents and representatives from any liability, injury or damages caused by or arising from or in connection with my presence as an observer in the hospital.

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Purpose of the observation (“shadowing”) experience

______________________	______________________
Observer’s Name (Please Print)	Physician Being Observed (Please Print)
______________________	______________________
Signature of Observer	Witness Signature
______________________	______________________
Dates of Observation	Date of Signature
______________________	______________________
Signature of Parent/Guardian if under 18 years old	Person to notify in case of an emergency