Tel: 212-241-8300
Fax: 646-537-9679
www.mountsinai.org

International Personnel
Human Resources

Mount Sinai Beth Israel
Mount Sinai Beth Israel Brooklyn
The Mount Sinai Hospital
Mount Sinai Queens
Mount Sinai Roosevelt
Mount Sinai St. Luke's
New York Eye and Ear Infirmary of Mount Sinai
Mount Sinai Health System

Confidential Application for Observership

(Please Type or Print Neatly)

General Information

Name:_____
Foreign Address: _____
Country: _____ Phone Number:_____
E-mail Address: _____
If you are under 18, please state your age:_____

Education

Please indicate your highest level of education:

☐College ☐Post-Bacc Program ☐Graduate School
School:_____
Degree: _____ Major _____
☐ Obtained ☐ In Progress / Anticipated year of graduation/completion: ____

Department Information

Name Of Department:_____
Direct Supervisor: _____ Administrator: _____
Administrator Phone#:_____

Immigration Information

Current Immigration Status: ☐ B-1/B-2 ☐Visa Waiver ☐Other_____
I-94#_____ I-94 Expiration Date _____
Date of Entry/Proposed Entry:_____ Port of Entry: _____
Passport Issuing Country:_____ Visa Expiration _____
Passport Expiration date: _____

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By signing this agreement, I _____ request to observe in the department of _____ with _____ at Mount Sinai_____, between ___/___/ ___ and ___/___/ ___, but no longer than 30 days unless a toxicology screening is provided allowing me a maximum of 90 days per year.

1. I agree this observership is not being done as an academic requirement and understand that I will not receive any academic credit from Mount Sinai for this experience.

2. I understand that I **will not** receive any compensation or remuneration.

3. I understand that I **will accompany** the above staff member on duty and observe.

4. I understand that I am **not permitted** to have any direct patient contact, or provide patient care (i.e. cannot question or examine patients; cannot scrub in to participate on surgical cases of any patient) other than accompanying and observing a physician as state above.

5. I understand that I am **not permitted** to have independent access to patient information.

6. I understand that I **cannot** engage in any clinical, clerical, administrative or other research activity including, but not limited to, data entry, laboratory work, article review etc.

7. I understand that I **cannot** access Mount Sinai computers and/or review laboratory test results and computer-based diagnostic imaging results in order to be able to write a case report or observations on small patient groups for publication.

8. I will comply with all Mount Sinai policies and procedures including patient confidentiality and applicable provisions of federal, state and local law, including the Health Insurance Portability and Accountability Act (HIPAA).

9. I understand that Mount Sinai may, at its discretion, terminate this experience at any time.

10. I understand that I must satisfy Mount Sinai employee health center requirements for medical clearance before I begin.

11. I am required to provide copies of any relevant licenses or a letter from my home institution verifying my credentials.

12. I will not wear white lab coats in patient care areas.

I have read and understand the information above and agree to abide by it.

_____	_____	_____
Printed Name of Observer	Signature of Observer	Date

I have read and agree to comply with the above stipulations in supervising this observer.

_____	_____	_____
Printed Name of Supervising Staff	Signature of Supervising Staff	Date
_____	_____	
Direct Phone Number	E-mail Address	