

Texas Children's Short-Term Observership

An Observership provides a unique opportunity for individuals to shadow healthcare provider at Texas Children's. Short-term observership opportunities are available to individuals that have obtained approval from a Texas Children's / BCM clinical team member or supervisor and have agreed to sponsor the observation experience. The onboarding and coordination of the observership is completed by the sponsoring department. Texas Children's Human Resources or Volunteer Services offices do not serve as a placement service for individuals who are interested in an observership or record Observer hours.

1. [Click here](#) to fill out the Texas Children's Observer application.
2. Complete all forms included in this packet and submit to sponsoring department contact.
 - a. Submit/scan all documents in one email communication.
 - b. Incomplete scans or emails with partial information will not be accepted.
3. The sponsoring department at Texas Children's Hospital will retain all forms.

OBSERVER COVER SHEET

NAME _____

EMAIL ADDRESS _____

PLACEMENT:

Department sponsoring Observer experience _____

TCH staff member or BCM physician sponsor _____

Sponsor phone _____

Prior Observer experience at TCH? _____

For office use

Health screen sent/faxed _____

Health screen cleared _____

BCM clearance _____

Observership- Onboarding Requirements Checklist

- ☐ Confirmed Texas Children's clinical team member or supervisor sponsor
- ☐ Completed Texas Children's Observership Application
- ☐ Completed Health Packet
 - Health History Questionnaire
 - Immunization Requirements
 - Tetanus/Diphtheria/PertussisTdap vaccine- Documentation of at least one (1) dose of tetanus-diphtheria-pertussis (Tdap), then Td booster every 10 years.
 - Measles (Rubeola)- Acceptable proof of prior immunization with two (2) doses of vaccine; or serologic confirmation of immunity
 - Mumps- Acceptable proof of prior immunization with two (2) doses of vaccine; or serologic confirmation of immunity.
 - Rubella- Proof of prior immunization with one (1) dose of vaccine on or after first birthday; or serologic confirmation of immunity.
 - Varicella- Documentation of immunization, two (2) doses at appropriate interval or serologic proof of immunity. *Written physician documentation of disease history is acceptable.*
 - Influenza (Flu)- A dose of flu vaccine every flu season/ annually (September - March)
 - Tuberculosis- QuantiFeron TB Gold/T-Spot test results within the past 12 months is acceptable or TB skin test within the past 12 months.
 - If previous positive TB skin test; proof of positive TB test and a chest x-ray are required.
- ☐ Security background clearance
 - Submit a copy of your driver's license
- ☐ Receive Observer badge (MAIN AND WEST CAMPUS)
- ☐ Completed Privacy and Confidentiality Agreement
- ☐ Review Alternate Orientation
- ☐ Complete Clinical Observership department orientation
- Other Onboarding Elements:**
 - Confirm schedule and start date with department sponsor
 - Confirm parking information with department sponsor
 - Review department specific dress code



HEALTH HISTORY QUESTIONNAIRE

NAME _____ DATE _____
SOCIAL SECURITY# _____ - _____ - _____ AGE _____ MALE _____ FEMALE _____
HOME PHONE _____ DATE OF BIRTH _____
E-MAIL ADDRESS _____
PERSONAL PHYSICIAN'S NAME _____
IN EMERGENCY, NOTIFY _____ PHONE # _____

Submit a copy of your immunization record

***Please Note: in lieu of an immunization record, serologic confirmation of immunity (titers) for Rubella, Rubeola (Measles), Mumps, and Varicella (chickenpox) will be accepted.**

Immunization Requirements

- Tetanus/Diphtheria/Pertussis TDap vaccine- Documentation of at least one (1) dose of tetanus-diphtheria-pertussis **(Tdap)**, then **Td booster every 10 years.**
- Measles (Rubeola)- Acceptable proof of prior immunization with two (2) doses of vaccine; or serologic confirmation of immunity.
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ARE YOU CURRENTLY PREGNANT? YES _____ NO _____

PLEASE LIST ALL PRESCRIPTION MEDICATIONS THAT YOU ARE CURRENTLY TAKING:

Do you have any health concerns which might limit your ability to perform certain volunteer responsibilities: Yes _____ NO _____

If yes, please explain: _____

FOR EMPLOYEE HEALTH USE ONLY:

MD NOTE REQUESTED _____

CXR PENDING _____

Have you ever had or do you now have any of the listed conditions? Explain when and where a treatment was received for all "YES" answers in the space provided.

	<u>NO</u>	<u>YES</u>	<u>EXPLANATION OF ANSWER</u>
Alcoholism	_____	_____	_____
Arthritis	_____	_____	_____
Asthma/Emphysema	_____	_____	_____
Back Trouble	_____	_____	_____
Breathing Difficulty	_____	_____	_____
Cancer	_____	_____	_____
Chest Pains	_____	_____	_____
Diabetes	_____	_____	_____
Drug Abuse	_____	_____	_____
Epilepsy/Seizure	_____	_____	_____
Fainting/Dizziness	_____	_____	_____
Hernia	_____	_____	_____
Hearing Problem	_____	_____	_____
Heart Problem	_____	_____	_____
Hepatitis	_____	_____	_____
High Blood Pressure	_____	_____	_____
High Cholesterol	_____	_____	_____
Knee, Foot or Ankle	_____	_____	_____
Problem	_____	_____	_____
Liver Disease	_____	_____	_____
Nervous Breakdown/ Psychiatric Illness or Treatment	_____	_____	_____
Obesity (overweight)	_____	_____	_____
Stroke	_____	_____	_____
Surgery	_____	_____	_____
Ulcers	_____	_____	_____
Vision Problem	_____	_____	_____
Other	_____	_____	_____

I hereby declare that my answers to the above questions are complete and true. I agree that any false statement shall be sufficient cause for dismissal. I hereby grant permission to Texas Children's Hospital to investigate any information included in this form, and to contact my personal physician (listed on page 1 of form) with regard to the information given. I understand that any information given to Texas Children's Hospital by either myself or my physician will remain confidential.

Signature of Observer _____ Date _____