Shirley Ryan AbilityLab

Observership Program Application Checklist

I. **General Instructions:** Submit all application materials as listed below to the Observership Coordinator at the Shirley Ryan AbilityLab at least **three months** before the anticipated date of arrival. All required documents must be included in order to consider the application.

Required Documents Checklist	
Signed Application Form	☐
Signed Confidentiality Agreement for Patient Observation	☐

Immunization Record:
• Documentation of immunization status for measles, mumps, rubella. Acceptable documentation from a health organization of 2 each of measles, mumps, rubella (or two MMR's) vaccines or titers showing immunity.
• Varivax (varicella zoster vaccine) or documentation of immunity to chicken pox and Hepatitis B. Acceptable documentation from a health organization of 2 varicella vaccines or titer showing immunity.
• Evidence of screening for tuberculosis:
  ○ Documentation of 2 TB skin tests within the past 12 months. The second TB test must be within 3 months to the start of the observership.
  ○ 1 TB blood test (Quantiferon) drawn within 3 months to the start of the observership
  ○ X-ray report for positive reactors current within five years and screening for TB symptoms
• Flu vaccination if visiting between October 1st – March 31st
• COVID-19 Proof of Vaccination, at least one of the following:
  ○ A letter of attestation from the medical provider who administered the vaccination(s) to the Observer
  ○ A copy of the Observer's completed vaccination card
  ○ Documentation of vaccination from the Observer's medical record
  ○ Documentation of the Observer's vaccination from a city, province or country vaccine registry
	☐

Health Insurance Documentation	☐
Non-refundable $100.00 Application Fee	☐

Additional Requirement for Non-US Citizens	
Proof of English Proficiency. Provide one of the following: • Letter from a medical faculty member in the United States who has personal knowledge of your English fluency. • English Test Scores such as the TOEFL or the Michigan Test. • Letter from an English teacher who has personal knowledge of your fluency in English.	☐

II. Policies

A. For any questions concerning the status of your application, please contact the Observership Program Coordinator.

B. Observerships last no more than two weeks.

C. No stipend support, compensation, insurance coverage, benefits, or housing will be provided by Shirley Ryan AbilityLab.

D. The Shirley Ryan AbilityLab Observation Program is performed on a voluntary basis and the Observer is not considered a Shirley Ryan AbilityLab employee.

E. The Observer will not receive any academic credit for the program. The program does not constitute medical education, graduate medical education, continuing medical education or training leading to licensure or board certification. The Observer is not a student, resident or clinical staff member of Shirley Ryan AbilityLab, and must not represent him/herself as such.

F. Shirley Ryan AbilityLab does not discriminate with regard to sex, race, color, age, creed, or national origin in judging an applicant's qualifications to become an Observer.

G. Approval of the Observership Program application is at the discretion of the Academy and we cannot guarantee preferred program dates.

H. Once accepted into the Observership Program, the Observer must:
   1. Wear appropriate identification at all times at any Shirley Ryan AbilityLab site.
   2. Abide by all policies, rules and bylaws of Shirley Ryan AbilityLab.

3. Be supervised by a physician or clinical designee at all times when in the presence of patients.
4. Introduce him/herself to the patient as an Observer, and must request, in advance, the patient's permission to be present at the time of a clinical visit, procedure or other services.

I. Upon satisfactory completion of the Observership Program, Shirley Ryan AbilityLab will provide the Rehabilitation Observer with a Certificate of Acknowledgment.

J. Rehabilitation Observer Privileges:

Privileges Granted to Observers	**Privileges Denied to Observers**
Observers may:	*Observers may not:*
1. Participate in grand rounds, seminars, courses or other didactic activities.	1. Administer treatment or render services to patients or patient's families (including a primary medical examination, history, physical or counseling).
2. Participate in case conferences or chart rounds with proper patient consent.	2. Be involved in obtaining patient consent for any clinical or research procedures.
3. Observe walking rounds with proper patient consent.	3. Participate in decisions concerning patient management; write orders or notes in patient charts; or give orders verbally or otherwise.
4. View and discuss patient interactions with supervising physician or clinician with proper patient consent.	4. Participate as a member of a patient's clinical care team.
5. Observe both inpatient and outpatient clinical activities with proper patient consent.	
6. Utilize educational resources of the Henry B Betts Life Center.	

Shirley Ryan Abilitylab

Observership Application

Applicant Information

First Name: First Name Last Name: Last Name

Email: Email Telephone: Telephone

US Citizen: ☐ Yes ☐ No

Mailing Address

Street Address: Number and Street Address

City: City

State: State (If applicable)

Country: Country

Zip Code: Zip Code

Emergency Contact

Name: Name Relationship: Relationship

Email: Email Telephone: Telephone

Academic History

Institution Name	City, State, Country	Dates Attended From/To (month/day/year)	Major Field of Study	Degree	Date Awarded or Expected (month/day/year)

Certification/Licensure

Certification / Licensure Type	Date Granted (month/day/year)	Granting Agency

Employment and Training Experience

Dates From/To (month/day/year)	Type of Experience (i.e.: Teaching Intern, Military, Residency, Practice, Etc.)	Institution	City, State, Country

2 Professional References

Please provide contact information for two professionals who can attest to your ability.

Reference 1:

First Name: First Name Relationship: Relationship

Last Name: Last Name Title: Title

Email: Email Telephone: Telephone

How long have they known you?: # Years Address: Address

Reference 2:

First Name: First Name Relationship: Relationship

Last Name: Last Name Title: Title

Email: Email Telephone: Telephone

How long have they known you?: # Years Address: Address

Statement of Intent

In the area below please identify your goals, objectives, expectations and areas of interest as a Rehabilitation Observer. Attach additional sheets as necessary.

[Type your statement here]

Proposed Dates for your Observership

Application must be received at least 3 months before your proposed dates. We will make every attempt to accommodate your preferences but cannot guarantee these dates as it based on our clinicians' availability and schedules as well. Please remember, observerships are no longer than 2 weeks in length.

First Choice: Anticipated Date of Arrival and Departure

Second Choice: Anticipated Date of Arrival and Departure

Third Choice: Anticipated Date of Arrival and Departure

Acknowledgements

Please read the following statements carefully before signing your application.

I understand that all application material submitted to the Shirley Ryan AbilityLab becomes the property of Shirley Ryan AbilityLab and is not returnable.

I understand that the information submitted herein will be relied upon by the Shirley Ryan AbilityLab to determine my status for eligibility as Observer. I authorize Shirley Ryan AbilityLab to verify the information I have provided. I understand that any omission of requested data may jeopardize my consideration for the Rehabilitation Observer program. I agree to notify the proper Shirley Ryan AbilityLab employees to any changes in the information provided. I understand that the scope and privileges of the program are listed in the Observership Program Application Checklist document, Section II, and no modifications are allowed in the program.

COVID Symptoms and/or Diagnosis: I understand that Observers are required to self-screen for symptoms prior to being on-site at any SRAlab facility. I understand that if I am exhibiting COVID symptoms, I am prohibited from entering any SRAlab facility until I receive negative test results. I understand that if I am diagnosed as having COVID, even in the absence of a positive test result, I am prohibited from entering any SRAlab facility until I am either medically cleared by a licensed healthcare provider or satisfy the requirements of CDC's Return to Work Healthcare Guidance. I acknowledge that SRAlab retains the right to request and receive proof of negative test results, medical clearance by a licensed healthcare provider, or satisfaction of the requirements of CDC's Return to Work Healthcare Guidance at any time, including prior to allowing my return to any SRAlab facility. I understand I am required to be in receipt of such proof and attests that it will be able to provide such proof upon request. I agree that an inability to provide such proof upon request will result in being barred from physically entering any SRAlab facility until such time as the proof is provided. I agree that ongoing failure to comply with a request by SRAlab for such proof will result in termination of the Agreement for cause.

I certify that the information in the application is complete and correct to the best of my knowledge and belief. I acknowledge the submission of any false information is grounds for rejection of my application or termination of my Observership.

Signature: Date:

Release of Information

I release from liability and from any restrictions as to confidentiality or privacy of all hospitals, schools, physicians, clinicians, employers, individuals, agencies or organizations that provide information about me at the request of the Shirley Ryan AbilityLab or its agents.

Signature: Date: