Preceptor Agreement (U.S.)

The Observership Preceptor (Sponsor) agrees to the following:

- To conduct the departmental orientation, including expectations in HIPAA and universal precautions.
- To provide direct supervision for the Observer when in Swedish Medical facility
- To introduce the Observer and obtain patient consent to have the Observer present
- To guide the Observership experience to meet the agreed upon objectives with the observer

All observerships are limited to a maximum of forty (40) hours within a one (1) month period. If 40 hours, then the hours may be scheduled as:

- A consecutive work-week of up to five (5) full days, or
- Five (5) full days or ten (10) half days distributed over a one-month period

There is a minimum lead-time of three (3) full weeks to set up an observership from the date of submission of this Agreement. Please factor in this time when deciding on the first date of an observership.

Please DO NOT enter “To Be Determined” or “TBD” for dates or times. You must determine the dates and times when completing this agreement.

Date(s): _________________________ Time(s): _________________________ Campus: _________________________

The onsite contact person for the Preceptor (Sponsor) office is:

Name: ___________________________
Email: ___________________________
Phone: ___________________________

I have read the Observer Policy and Procedures, reviewed this application, and I approve of this Observership. I also agree to provide supervision of the observer at all times when in Swedish Medical facilities. I understand that I am solely responsible and liable for my observer.

Preceptor / Sponsor ___________________________ Signature ___________________________ Date ________________

The Observer agrees to the following:

- I will not receive any academic credit from the sponsoring institution for this experience.
- I will accompany a medical staff member on duty and observe
- I will not be allowed independent, direct patient contact.
- I will leave any patient area in which a patient does not consent to my being present.
- I will not have independent access to patient information.
- I will comply with all of Swedish Medical Center or Swedish Medical Group policies and procedures including patient confidentiality and applicable provisions of federal, state and local law, including the Health Insurance Portability and Accountability Act (HIPAA).
- I understand that sponsoring institution may, at its sole discretion, terminate this experience at any time

Applicant Name ___________________________ Signature ___________________________ Date ________________

Copy to be uploaded with online Observer Application.

Graduate Medical Education | Swedish Medical Center – First Hill Campus
747 Broadway, Seattle, WA 98122-4307 (WW-A23)
206-320-5301 | GMEOnboarding@swedish.org | http://www.swedish.org/gme