Application for Observer

NAME: _____ **LSUHSC-S FACULTY SPONSOR:** _____
Last (Family, Surname) First (Given) Middle

PROPOSED APPOINTMENT DATES, FROM: _____ **TO:** _____
month/day/year *month/day/year*

COUNTRY OF CITIZENSHIP: _____ **LSUHSC-S DEPARTMENT/DIVISION:** _____

If you are a U.S. permanent resident, check here ☐

Required Documents Checklist Please submit a complete set of these application materials to your Faculty Sponsor.
This completed application form (pages 1-4 for applicant)
Copy of photo identification:
For U.S. citizens: Copy of federal or state-issued photo identification
For U.S. permanent residents: Copy of Permanent Resident Card
For non-U.S. citizens/permanent residents: Copy of passport identification page, visa stamp, Immigration forms (I-20, DS-2019, I-797, etc.) and Form I-94 (if applicable)
Résumé or C.V. (**in English**, listing academic history, certifications, licensures, employment, and training experience)
Health form(s) *(with supporting documentation as requested on the form, including English translations, if applicable)*
Observer fee: non-refundable $500.00 USD application processing fee
For **MD Observers in the clinical areas**: Copy of diploma (highest degree) **and** documentation of graduation from a medical school listed in the International Medical Education Directory (IMED) (www.faimer.org). (directly submitted by that medical school), PLUS documentation of one of the following: 1. copy of score report demonstrating passing score on at least USMLE Step 1 and Step 2 CK, or 2. USMLE transcript, Educational Commission for Foreign Medical Graduates (ECFMG) Status Report or ECFMG Certificate, or 3. active, unrestricted US medical license, or its equivalent in the country in which the applicant practices medicine. For **Observers from other Healthcare Professions** in clinical areas: Copy of diploma (highest degree) plus documentation of graduation from the appropriate professional school submitted directly by that educational program/institution.
For Pre-Baccalaureate Observers: A letter, from the Applicant's home institution, confirming enrollment and in good standing.

If you have questions concerning the status of your application at any time, please contact the Office of the Registrar.

Please allow minimum of four (4) weeks for the approval process.
Application should be submitted no more than six (6) months prior the proposed dates.

Biographical Information - Please type or print legibly. If we can't read your writing, your application will be denied.

Full Legal Name: _____
Last (Family, Surname) First (Given) Middle

Gender: ◯ Male ◯ Female Date of Birth: _____ 19__
month / day *year*

Permanent Mailing Address: _____
No. and Street Apartment No.

_____
City State/Province Zip/Postal Code Country

_____ _____
Phone E-mail Address

Emergency Contact Information: _____
Name Relationship Phone

Shreveport Area Address: _____
(if known, and if different from Permanent Address)
No. and Street Apartment No.

_____
City State Zip Code

_____ _____
Local Phone Number E-mail Address

Have you ever had a felony or equivalent criminal conviction? ◯ Yes ◯ No
If yes, attach details of conviction, including dates.

Have you ever studied, observed, worked, or volunteered at LSU Health? ◯ Yes ◯ No

If yes: In what capacity? (Student, Observer, Employee, Postdoctoral Fellow, Volunteer, etc.) _____

Dates: _____ -- _____ Name of Faculty Sponsor: _____
month/day/year – month/day/year

School/Department: _____

Statement of Intent

Please state the objectives of your association, as well as the benefits you expect to receive from this experience:

For foreign nationals who are not U.S. citizens or U.S. permanent residents:

Passport #: _____ Issued by: _____

Country of Birth: _____ Country of Last Legal Permanent Resident: _____

Country of Citizenship: _____

Do you currently have a U.S. visa? ○ Yes ○ No If yes, what type? _____ Exp. Date: _____ *month/day/year*

Are you currently in the U.S? ○ Yes ○ No If yes, I-94# (11-digits): _____ Exp. Date: _____ *month/day/year*

Do you have a U.S. Social Security Number? ○ Yes ○ No *If yes, you will be contacted at a later time to provide it directly for a background check (please do not write your U.S. Social Security number here).*

Please note:

- Foreign Nationals (non-U.S. citizens/permanent residents) may ***not*** begin their association with LSU Health until the their visas are reviewed and approved by the Office of Legal Affairs.
- ***Foreign Nationals (non-U.S. citizens/permanent residents) must have a valid U.S. immigration visa status necessary for the full period of the proposed visiting activity.***
- Applicants holding temporary visas are bound by the restrictions placed on LSU Health by the U.S. Department of Homeland Security and the U.S. Department of State.
- Please direct visa-related inquiries to Carol Peterson in the Office of Legal Affairs at 318.675.5571.

Acknowledgements - Read the following statements carefully before signing.

In consideration of LSU Health allowing me to participate in this association and for other good and valuable consideration, I agree and attest as follows:

A. I certify that I have requested and am entering into this association without any promise or expectation of financial compensation or offer of employment or other appointment by LSU Health.

B. I understand that all application material submitted to LSU Health becomes the property of LSU Health and is not returnable. I also understand that LSU Health is not obligated to furnish me with duplicate copies.

C. I understand that the information submitted herein will be relied upon by LSU Health to determine my status for eligibility for this association. I authorize LSU Health to verify the information I have provided. I understand that any omission of requested data may jeopardize my consideration for this association with LSU Health. I agree to notify the proper LSU Health officials of any changes in the information provided.

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

E. I affirm and agree that at all times during my association with LSU Health and at any time while on the premises of LSU Health, I will comply will all applicable federal, state and local laws and regulations and all policies and procedures of LSU Health.

F. I agree to complete at LSU Health any and all required training relevant to my association with LSU Health, including but not limited to training on safety, confidentiality, and

G. If I am an Observer in a clinical setting, I will review and understand the Ochsner LSU Health "*OLHS Health Care Observer Agreement"* and, I agree to and will sign the "*Confidentiality*" document.

H. I agree to comply with the privacy and security rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and LSU Health's policies regarding the privacy of individually identifiable health information, including but not limited to those contained the "*LSU Health Shreveport Code of Conduct*" and the "*LSUHSC-S Compliance, HIPPA and Information Student Guide"* and will sign the relevant documents.

I. I understand that I may become aware of or acquire information that is the intellectual property of LSU Health and which may be proprietary in nature ("LSU Health IP"). This intellectual property may consist of unpublished results, know-how, non-patentable information, patentable or other written or orally transmitted information. I agree to hold all such LSU Health Intellectual Property in confidence and further agree that no LSU Health Intellectual Property that I have become aware of or that has been acquired by me will be transmitted by me in any form to a third party.

J. As a component institution of the University, LSU Health abides by Chapter VII of the Louisiana State University Board of Supervisors Bylaws and Regulations regarding Intellectual Property. To the extent that an invention or other intellectual property arises from my association with LSU Health, the invention and intellectual property will be automatically owned by the University. I agree to disclose promptly, in writing, and agree to assign and hereby do assign all rights in any and all inventions and creations, whether or not patentable, that are created by me during the term of this association (the "Intellectual Property") to the LSU Board of Supervisors, on behalf of LSU Health. I agree to sign any and all documentation that is required to perfect or evidence this assignment and all documents reasonably necessary for the Board and LSU Health to protect Intellectual Property.

K. I agree that I am not authorized to engage in (i) the diagnoses of disease or other conditions in humans; or (ii) the cure, mitigation, therapy, treatment, treatment planning, or prevention of disease in humans or to affect the structure or function thereof, irrespective of whether or not I am certified or qualified for any of the foregoing.

M. I represent and certify that (a) I am not a person who has been designated as a specifically designated national or blocked person under applicable U.S. law or regulation, and (b) neither I nor any entity with which I am employed or otherwise affiliated is (i) a person or entity with whom U.S. persons or entities are restricted from doing business under U.S. law, executive power, or regulation promulgated there under by any regulatory body, or (ii) in violation of any U.S. money laundering law.

N. I understand that I will be subject to a background check in accordance with LSU Health's policy on Criminal Background Checks (US Citizens and Permanent Residents).

O. I understand that my association with LSU Health may be revoked at any time by LSU Health without cause and without advance notice to me (including the application process).

P. I agree to indemnify and hold LSU Health and The University, the LSU Board of Supervisors, officers, agents, and employees, harmless from any loss, claim, damage, injury, or liability of any kind arising out of or in connection with my association with or presence at LSU Health.

Q. 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 association with LSU Health.

Signature of Applicant _____ **Date** _____

(hand written signature required)

The non-refundable application processing fee is required with the application. <u>Do not send personal check or cash</u>

O 500.00 USD Money order drawn on a U.S. bank and made payable to: LSUHSC-S

PayPal available on request

For office use only **Payment received on:** _____ **by** _____

Please include all required documentation (see page 1) with this application and submit to the Faculty Sponsor or sponsoring department. ***NOTE:*** *Applications are reviewed and evaluated by the Vice-Chancellor for Academic Affairs for final approval. After this approval process, the Applicant may come to LSU Health for the Purposes stated herein, contingent upon an appropriate visa being obtained (if applicable) and any additional agreements being successfully executed (if applicable). Once all the paperwork is in order, the Applicant must also complete the following intake process* ***before starting the visit****:*

1) Check-in with Registrar's office to initiate badge processing and complete Compliance Paperwork