Brigham and Women's Hospital
Founding Member, Mass General Brigham

BWH Physician Assistant Shadowing Policy

Please review all information

Shadowing is limited to one experience and is typically around 4 hours

Important information:

- Attire: Business casual attire or scrubs with no open toed shoes.
- If you are not feeling well on the day you are scheduled to come in, stay home! We will find another day to shadow.
- Confirm the day and time of arrival for your shadowing at least 48 hours in advance. Be sure to confirm where you are supposed to meet the PA.

Clinical Observational Experiences (COE) at Brigham and Women's Hospital will

- Provide observers with appropriate educational observations in a closely supervised safe environment.
- Protect the rights and dignity of the BWH patient without adversely impacting clinical care.
- Maintain the confidentiality and security of protected health information (PHI), and other proprietary or confidential information.

Observer Participation & Limitations:

The observer can introduce themselves to a patient but cannot participate in the patient's care, documentation of care, or give even the appearance of being a caregiver. Importantly, the observer may not take a medical history, or touch or examine a patient. The observer should not interact with family members of the patient. Observers are not allowed to place medical orders, provide verbal orders, or convey medical recommendations to other patients or other healthcare members. The observers are not hospital employees or members of the professional staff and may not represent themselves as such.

Operating Room, PACU, Labor & Delivery:

Access to these locations is granted only by unique circumstance with awareness and approval by the Department Chief overseeing the PA sponsor. In the Operating Room, PACU, and Labor & Delivery, observers must always be in the company of the PA sponsor.

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Infection Control Standards for Health Clearance

- **Tuberculosis (TB) Screening Required**
  One of the following is required:
  a. Documentation of TB skin test within 3 months of screening date
     OR
  b. Documentation of a negative IGRA (QFT or T-Spot) within 3 months of screening date
     OR
  c. For individuals known to be TB skin test positive or who have positive IGRA, documentation of a chest x-ray report which rules out active tuberculosis is required and a completed TB symptom survey

- **Measles, Mumps, and Rubella Immunity Required**
  One of the following is required:
  a. Documentation of two MMR vaccines **OR** two measles vaccines, two mumps vaccine, and one rubella vaccine
     OR
  b. Proof of immunity to measles, mumps, and rubella by IgG antibody titer (blood test).

- **Chicken Pox (Varicella) Immunity Required**
  One of the following is required:
  a. History of Varicella
  OR
  b. Proof of immunity to chicken pox by IgG antibody titer (blood test)
  OR
  c. Documentation of two varicella vaccinations

- **Influenza Vaccination Required**
  Mass General Brigham requires all health care workers to receive a **seasonal** flu vaccine.

- **COVID Vaccination Required**
  Mass General Brigham requires all health care workers to be up to date with COVID-19 vaccinations.

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Health Screening Requirements

First Name: _____ **Last Name:**_____ **Date of Birth:** _____

Must be Completed by Personal Health Care Provider or School Health Office:

All personnel who will work, volunteer, or observe at a Mass General Brigham healthcare facility are required to meet the minimal infection control standards on page 1.

Tuberculosis (TB):

BAMT within 3 mos. of screening date	QFT Date: _____ Result: _____		OR		T-Spot Date: _____ Result: _____			
For history of +TST or +BAMT a Chest X-Ray (CXR) is required	CXR Date: _____				Chest X-Ray Result_____			
LTBI TX	Dated of Completion: _____		OR		LTBI TX Not Completed_____			
Symptom Review *(Only for applicants who have a history of a positive PPD)*	Loss of appetite	❒ Yes	❒ No		Fever	❒ Yes	❒ No	
	Unexplained weight loss	❒ Yes	❒ No		Fatigue	❒ Yes	❒ No	
	Night Sweats	❒ Yes	❒ No		Productive Cough	❒ Yes	❒ No	

TB SCREENING:
Have you lived for more than one month in a country with a high rate of TB? (Any country other than the United States, Canada, Australia, New Zealand, and those in Northern Europe or Western Europe) YES _____ NO _____
Are you immunosuppressed? YES _____NO _____
Have you had close contact with someone who had infectious TB disease since your last TB screening? YES____ NO ____

Other Requirements

		Date		Date	Titer Result (circle)	Date
MMR	MMR #1	_____	MMR #2	_____		
Measles	Measles #1	_____	Measles #2	_____	POS / NEG	_____
Mumps	Mumps #1	_____	Mumps #2	_____	POS / NEG	_____
Rubella	Rubella #1	_____			POS / NEG	_____
Hx of Varicella	Yes___		No____			
Varicella	Varicella #1	_____	Varicella #2	_____	POS / NEG	_____
COVID 19	COVID 19 #1	_____	COVID19 #2	_____	Booster:	_____
	Manufacturer:	_____	Manufacturer:	_____	Manufacturer:	_____
Influenza (Seasonal)	Influenza	_____				

Provider Name (Print): _____ **Phone:** _____

Provider Signature: _____ **Date** _____

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CONFIDENTIALITY AGREEMENT

Mass General Brigham, its affiliates and joint venturers, have a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their health information. Additionally, Mass General Brigham, its affiliates and joint venturers, must assure the confidentiality of its patient, fiscal, research, computer systems, management and other business information. In the course of my employment/assignment at a Mass General Brigham organization/practice, I may come into the possession of confidential information. In addition, my personal access code [User ID and Password] used to access computer systems is also an integral aspect of this confidential information.

By signing this document, I understand the following:

1. Access to confidential information without a patient care/business need-to-know in order to perform my job - whether or not that information is inappropriately shared - is a violation of this policy. I agree not to disclose confidential or proprietary patient care and/or business information to outsiders (including family or friends) or to other employees who do not have a need-to-know.
2. I agree not to discuss confidential patient, fiscal, research, computer systems, management and other business information, where others can overhear the conversation, e.g., in hallways, on elevators, in the cafeterias, on the shuttle buses, on public transportation, at restaurants, at social events. It is not acceptable to discuss clinical information in public areas even if a patient's name is not used. This can raise doubts with patients and visitors about our respect for their privacy.
3. I agree not to make inquiries for other personnel who do not have proper authority.
4. I know that I am responsible for information that is accessed with my password. I am responsible for every action that is made while using that password. Thus, I agree not to willingly inform another person of my computer password or knowingly use another person's computer password instead of my own.
5. I agree not to make any unauthorized transmissions, inquiries, modifications, or purgings of data in the system. Such unauthorized transmissions include, but are not limited to, removing and/or transferring data from Mass General Brigham's computer systems to unauthorized locations, e.g., home.
6. I agree to log off a Mass General Brigham workstation prior to leaving it unattended. I know that if I do not log off a computer and someone else accesses confidential information while the computer is logged on with my password, I am responsible for the information that is accessed.

Mass General Brigham, its affiliates and joint venturers, have the ability to track and monitor access to on-line records and reserves the right to do so. Mass General Brigham, its affiliates and joint venturers, can verify that those who accessed records did so appropriately.

I have read the above special agreement and agree to make only authorized entries for inquiry and changes into the system and to keep all information described above confidential. I understand that violation of this agreement may result in corrective action, up to and including termination of employment and/or suspension and loss of privileges. I understand that in order for any User ID and/or Password to be issued to me, this form must be completed.

Signature of Employee / Physician / Student / Volunteer / Non-Partners Personnel Date

Print Name