INTERN REQUEST TO OBSERVE PATIENT CARE OR ACCESS RESTRICTED INFORMATION

INTERN INFORMATION	Intern's Name:	Local Street Address:
	City, State, Zip:	Email: UFID:

The intern is currently: ☐ UF Student ☐ UF Staff ☐ UF Faculty ☐ Not affiliated with UF Current Institution

SPONSORING FACULTY INFORMATION	Faculty Sponsor's Name:	Title:	Phone Number:
	Office Location:	Department:	Division:
INTERN ROLE	**This intern will be performing duties that are primarily related to the following activities. The Faculty Sponsor will provide a letter of invitation/ job description that describes in detail the activities for each category checked.**		
	☐ Research ☐ Lab Assistance ☐ Clerical Assistance		Dates of Internship: _____ to _____

1. This intern will be observing patient care: ____ No ____ Yes
Please describe the extent of the patient contact: ___ Observation only ___ Interacting with patients
Other _____

List All Locations for Observation, both on-site and remote, including remote video viewing:

Procedures/Activities to be Observed
☐ Surgery ☐ Hospital ☐ Rounds ☐ Clinic Activities ☐ Labs ☐ Research ☐ Other: _____

2. This intern will have access to restricted information: ____ No ____ Yes
If yes, access to the following types of data will be as a result of: ___ Observing Activities ____ Other Activities
___ Names ___ Addresses ___ SSN's ___ Health record #'s ___ Diagnoses ___ Genetic Data ___ Lab Data
___ Psychol. Test Data ___ Other _____
What will the volunteer do with the information? ___View ___ Data retrieval ___ Data entry ___ Data Analysis
Other:_____ Where is the data located? _____

3. Sponsoring Faculty Member and Intern understand and agree that:
- _____ *(Faculty Initial)* _____ *(Intern Initial)* The intern shall not participate in patient care.
- _____ *(Initial)* The Sponsoring Faculty Member assumes full responsibility for the actions of the intern and agrees to ensure that the intern complies with all UF Health policies and procedures and applicable state and federal laws and regulations while interning.

I certify that the above information is true and complete to the best of my knowledge. Signature of Sponsoring Faculty Member:	Date of Request:

APPROVAL TO OBSERVE PATIENT CARE AND ACCESS RESTRICTED DATA	Department Approval:	Date:
	Office of Research Affairs Approval:	Date: