DEFINITION:
Visiting learners/students are defined as learners who are not enrolled students of Ohio State University Wexner College of Medicine or are not trainees/learners of OSUWMC (residents, fellows, employees or students in specific OSUWMC or OSUCOM sponsored programs).

RATIONALE:
This formal policy regarding visiting learners is in place to address the following:
1. To protect the privacy and safety of our patients;
2. To protect the faculty, clinical instructors, and other resources essential to the integrity of our education programs;
3. To respect the work load of our faculty and clinical instructors whose primary educational responsibility is to our learners at OSUWMC and OSUCOM.

Policies related to adult research volunteers:
Adults seeking to participate in research, as opposed to primary patient care contact, should proceed to the related section. Please note, adult research volunteers are required to adhere to confidentiality and training requirements outlined below.

Policies related to visiting learners/students:
All learners:
1. Must comply with all credentialing requirements of the OSUWMC, including:
   a. Documentation of immunizations and tuberculosis testing consistent with OSUWMC standards for healthcare personnel with patient contact, if any patient contact is anticipated or expected to occur.
   b. Completion of Health Information Privacy and Portability Act related training.
   c. Completion of basic training related to safety, including infection control and blood-born pathogens in accordance with medical center requirements.

For primary, secondary (high school) students seeking to visit:
- OSUWMC and the LLC prohibit shadowing experiences by individual secondary students except in organized activities such as the MD Camp.

For undergraduates from institutions other than OSU:
- Undergraduates from places other than OSU may not shadow.

For Ohio State University students seeking to visit:
- A student of The Ohio State University may request the opportunity to shadow a physician for one day only and one time only and must complete the “Privacy form” and provide evidence of required immunizations.
- Requests must be made at least three weeks prior to selected date
- Contact: Melissa Stahr, Coordinator of Undergraduate Educational Experiences, Department of Psychiatry
  Suite 117 OSU Harding Hospital, 1670 Upham Drive, Columbus, Ohio 43210
  614-293-8282; Melissa.stahr@osumc.edu
For non-OSU medical students seeking to visit

For Med 4 students from LCME affiliated (standard US medical schools):
- Med 4 students may apply via: http://medicine.osu.edu/students/visitinginternationalstudents/pages/index.aspx

For Med 4 students currently enrolled in international medical schools who are requesting rotations for credit:
The College of Medicine is not able to accept international students for clinical electives.

For licensed trainees and physicians
Residents and fellows from affiliated training programs
All requests for resident or fellow rotations from outside programs must be processed through the Department of Psychiatry Residency Office. They will be accepted on a space available basis.
- All residents MUST HAVE AN OHIO TRAINING LICENSE and thus, out of state residents must begin the process 3-4 months prior to an anticipated start date.
- All rotations must have a Program Letter of Agreement in place between the affiliated program and OSU
- Program Director must complete the GME Program Letter of Agreement and submit to the OSU GME office
- OSU GME office will then obtain signatures of agreement from affiliate institution
- Fellows or residents may not begin their guest rotation until the Program Letter of Agreement is completed and approved per OSU GME office
- Contact: Joenna Cynkar, 293-4540.

International medical graduate residents (no longer enrolled in medical school)
The Department of Psychiatry does not accommodate international medical graduates requesting observerships or externships.

Exceptions/Appeals Process
This policy is intended to inform and offer guidance but is not meant to be absolute or rigid in nature. If there are circumstances that are either not covered in this or the Medical Center policy or if there are extenuating circumstances for a situation covered in this policy that warrant additional review, a request for exception can be made. Such requests should outline the issue and should be sent to the Vice Chair of Education for review. All the information on the request form attached to this policy will also be required. Any exceptions will require the approval of the Chair of the Department of Psychiatry before they are considered official.

This policy is complementary to the attached Wexner Medical Center's Policy entitled: Ohio State University Medical Center: Eligibility Criteria for Visiting Students and Physicians
For Outside Rotators to OSU
Submit to GME Office

1) OSU Program Name
2) OSU Rotation Director (OSU faculty overseeing rotator, if different than Program Director)
3) Affiliate Site Name and Address
4) Affiliate Program Name Sponsoring Trainee
5) Affiliate Program Director Name
6) Name of Affiliate GME Office Contact
7) Affiliate contact – name, phone #, email
8) Rotation Dates
9) Rotation Length
10) Rotation Duration – on-going or one-time
11) Resident/Fellow(s) names for one-time rotations
12) OSU Rotation Education Goals/Objectives/Curriculum

Signature – Program Director ____________________________ Date ____________________________
The Ohio State University College of Medicine
Department of Psychiatry

STUDENT APPLICATION FOR SHADOWING
ONE DAY/ONE TIME ONLY

Student Applicant: _______________________________________________________

Last Name  First  M.I.

Local Address: __________________________________________________________ Phone: ______________

Number  Street  City  Zip

Email Address: __________________________________________________________

OSU undergraduate student_______  or  OSU graduate student___________

Major: ___________________________            Expected date of graduation:_______________

Brief description of interest in shadowing:
________________________________________________________________________________________________________________________

Any specific requests or areas of interest:
________________________________________________________________________________________________________________________

I verify that the information regarding my student status is correct and verifiable through the Ohio State University registrar.

_________________________________________             ______________________
Student Name                             Date

Return this form to the address below, along with the privacy form signed by student and immunization form signed by appropriate physician. Paperwork should be submitted at least one month prior to shadowing date.

The Department of Psychiatry     Attn: Melissa Stahr
OSU Harding Hospital, Suite 117
1670 Upham Drive
Columbus, Ohio  43210
The Ohio State University Wexner Medical Center
Verification of Vaccinations and Health Status for Visitation/Observation

To be completed by the **Visitor/Observer’s Health Care Provider**

I, (please clearly print your name): _______________________ am the licensed health care provider for **(please clearly print the patient’s name): ______________________________________________________.**

I certify and confirm that:

1. The patient has received these vaccinations. I have verified the vaccination status through documentation of vaccination or through laboratory evidence of current immune status:
   - Rubella Date: __________
   - Rubeola Date: __________ (since 1980)
   - Varicella Zoster Date: __________. If no Varicella Zoster administered, the individual has physician documented history of Chicken Pox or has laboratory evidence of current immune status. Check here to confirm □.

2. He/She □ Has □ Has Not either begun or completed a Hepatitis B series.
   There is a remote possibility that the patient could be exposed to blood or body fluids during their visit. The risks of Hepatitis B and the benefit of the Hepatitis B series should be discussed with the patient or the patient’s parent/guardian for safety of the patient.

   If the patient/patient’s parent or guardian has declined to receive the vaccination, Please have the patient/patient’s parent or guardian initial below to indicate that you have informed the patient or patient’s parent/guardian of the risk and that they have declined to receive the vaccination at this time. _____(Initial Here)

3. He/She □ Has □ Has Not received a PPD(TB test) within the past year.
   The results were □ Positive □ Negative*
   *If positive, did the individual receive a chest x-ray? □ Yes □ No □ N/A
   The results of the chest x-ray were: □ Positive □ Negative □ N/A

4. The patient is in good health status and is currently free of any cold, infection or other infectious condition:
   □ Y □ N

I certify that the above information is true. I understand that incorrect or untrue information places the health and safety of the patients, staff members and visitors of The Ohio State University Medical Center at risk.

_______________________________    Date: ___________________
(Signature of Health Care Provider)    (Month/Day/Year)

Return to Melissa Stahr  Department of Psychiatry, OSU Harding Hospital, 1670 Upham Drive, Suite 117  Columbus, Ohio 43210  Fax (614) 293-4200
Visitor/Observer Confidentiality Education Form

What You Need To Know About Patient Confidentiality As A Visitor or Observer At The Ohio State University Wexner Medical Center

It Goes Without Saying . . . Confidentiality Matters!

During your visit at OSU Wexner Medical Center, you may see or overhear patient information. Patient information is confidential and is protected by law. Because patient information is protected by law, you must follow certain rules while you are here.

You must:

- Respect the privacy and confidentiality of our patients
- Wait outside the patient’s room until the person you are shadowing has received the patient’s permission for you to enter.
- Only ask for or access/view information that you have been given permission to access/view.

You must not:

- Go into a patient’s room unless the person you are shadowing has received the patient’s permission.
- Access the patient’s chart or see patient information electronically. Special permission is required. The person you are shadowing must limit the amount of information you will be exposed to.
- Copy, remove or take identifiable patient information with you.
- Provide any treatment or help with patient care.

You must keep information confidential after your visit. If you need to write a report or do a presentation about your observation experience with your school/agency, do not talk about patients in a way that someone could identify them. If you need help, work with the staff member responsible for your visit. Otherwise, you may talk about patients with the person you are shadowing during your visit, but you may not talk to anyone about patients after your visit.

You will be removed from The Ohio State University Wexner Medical Center if you do not follow these rules or if you violate patient confidentiality. OSUWMC and/or your host program or institution may take additional action. Failure to follow these rules may also result in fines or criminal penalties.

Please sign below to indicate that the information you provided above is true and that you understand your responsibilities.

Visitor/Observer Signature: __________________________________________ Date: ______________

Print Name: __________________________________________________________ Date of observation: ______________

Return to Melissa Stahr, OSU Harding Hospital, Suite 117  fax: 614-293-4200

Education office will retain a copy of this form in the department files for 6 years.

College of Medicine / Office of Health Sciences
Adult (18 and over) Research Volunteer Application

Volunteer: Return this form to HR Professional of the Department where intend to volunteer.  
Department HRP: Return complete packet (including welcome letter) to COM/OHS HR in 255 Meiling Hall (292-1088); as well as PI and Department Administrator.

Application Date: _______________ Name of PI: Mary Fristad

Department Where Planning to Volunteer: Psychiatry

Dr. Mr. Mrs. Ms. Miss (Circle)  
Name: ____________________________________________________________________ (Please Print)

Date of birth: ___/___/____ Male ___ Female ___

Address: ____________________________________________________________________

Street City State Zip Code

Phone: (Home/Cell) ____________ (Office) _____________ E-mail __________________________

How long have you been a resident of Ohio? ______________

Occupation: ______________________ Name of Employer/College: _______________________

Employer's/College’s address: _____________________________________________________

Citizen/Permanent Resident Yes____ No____ Nationality_____________________________

Visa Type (if applicable)__________________________________________________________

Emergency Contact:______________________________________________________________

Name ________________________________ Address ________________________________

Phone Number: ______________________ Relationship______________________________

Family Physician: ______________________________________________________________

Name ________________________________ Phone Number _____________________________

High School: __________________________ Date of graduation: ________________

Name of college (if applicable):__________________________ Location: __________________
Degree(s)/Major: _____________________ Date of graduation (if applicable): ________________

Please list any relevant lab/research training (add pages, if necessary):___________________
____________________________________________________________________________
____________________________________________________________________________

Have you ever been convicted of a criminal offense? ___ yes ___ no____________________

If yes, you must provide details. A conviction will not necessarily bar you from volunteer service. Please use this space to describe the offense (add more pages, if necessary):________________________________________________________

REQUIREMENTS FOR ADULT VOLUNTEERS

1. Age: Adult Volunteers must be at least 18 years of age.

2. Application: All prospective Adult Volunteers must submit this application to the HR Professional at the academic department office. Submitting the application does not assure placement. The choice of applicants is determined on the basis of personal qualifications and traits as judged by the Principal Investigator and departmental Chair.

3. References: Volunteers must supply names and contact information of two personal references whom they have known for at least 2 years (not relatives).

4. Background Check: All volunteers must successfully pass background check (through electronic fingerprinting in ID Processing) prior to starting their assignment.

5. Letter of welcome: The departmental Chair or Department Administrator should write a letter welcoming the applicant to department and outlining his/her position description, and: the name of the Principal Investigator, a brief description of the research project, the techniques used, hours of work, duration of assignment potential workplace hazards, a statement that the volunteer will be supervised daily by the PI or qualified designee (name and title).

6. Safety Training: All volunteers are required to take the same safety training classes required of regular laboratory employees. Classes should be completed in the Computer Based Learning (CBL) system by the start date or no later than one week post-start date. To obtain access to CBL, a request for volunteer’s medical center account (e.g. JOHN99) must be submitted first, through the Service Now site. The form is called Non Hospital Employees Account Request. Once the non hospital employee account is created, the CBL account will be created within 48 hours. Those who do not need computer access, are required to complete the Confidentiality Education Form.

7. Biosafety: Volunteers and visiting scientists may not work in BSL 3 facilities, unless an agreement is made with the Institutional Biosafety Officer and background checks are completed.

8. Keys: University keys and door codes may not be issued to volunteers. Visiting Scientists may be issued keys if requested by the Principal Investigator and Department Chair.
10. **OSUWMC ID Badges** are required for Adult Volunteers. They must first pass their background check through fingerprinting with ID Processing in order to be issued an ID badge (or given computer access).

11. **Health:** Adult Volunteers are expected to be in good physical and mental health. He/she must have appropriate health exams and vaccinations before entering the research area/laboratory. Proof of health insurance and current tetanus and Hepatitis B vaccinations are required; a recent tuberculin (TB) test also may be required. The applicant's private physician or the Health Department can provide these records/services. If vaccinations/tests and other medical treatment are obtained at OSUWMC, the volunteer will be responsible for payment.

12. **Uniform:** Personal Protective Equipment: Adult Volunteers/unpaid visiting scientists must, when appropriate, wear a full-length lab coat or any other personal protective equipment (PPE) provided by the PI. High heeled shoes, open toe shoes or sandals, or shorts are not recommended to be worn in the laboratory. Clothing should completely cover the torso (no bare midriffs).

**Compensation:** The Volunteer understands and agrees that the relationship between the Volunteer and OSU is not that of employer and employee, that he/she shall have no authority to bind or act on behalf of OSU, that he/she is not entitled to receive compensation as a result his/her activities at OSU, and that he/she is not entitled to any sick leave, vacation pay, retirement benefits, social security, disability benefits, unemployment benefits, workers compensation benefits or any other benefits that OSU provides for its employees.

**Intellectual Property:** In the course of his/her work with the Principal Investigator, Professor____________________, the Volunteer may acquire information that is the intellectual property of OSU. This intellectual property may consist of unpublished results, know-how, non-patentable information, patentable or other written or orally transmitted information. The Volunteer agrees that no information acquired by the Volunteer during his/her tenure at OSU will be transmitted by the Participant in any form to any third party.

**Patents:** In the event that discoveries result from the Volunteer’s efforts at OSU, such discoveries and any resulting know-how, patent application or patent will be the property of OSU. Furthermore, OSU will be the owners of all intellectual property generated by the Volunteer during his/her tenure at OSU. This will include, but will not be limited to, know-how, patents, original data, computer programs and records of work. The timing, extent and content of all publications regarding the results of the activities under this Agreement shall be at the discretion of OSU and the Principal Investigator.

I understand that my placement as a volunteer in a research laboratory in The College of Medicine/Office of Health Sciences/OSUWMC will be mutually probationary and that it can be revoked at any time.

I also understand that The Ohio State University is not responsible for required vaccinations/tests, illness or injury, or for payment to a physician or emergency department encountered during my volunteer service.

The applicant agrees to hold OSU, their Regents, officers, agents and employees, harmless from any loss, claim, damage, or liability of any kind involving the Volunteer arising out of, or in, connection with this Agreement, except to the extent that it is directly due to the negligent acts or omissions of any of the Regents, officers, employees or agents of OSU.
I have read the above requirements, understand them, and wish to apply to be a Non-Affiliated Adult Volunteer.

Applicant’s signature: ______________________________ Date: ______________

Printed Name: ______________________________

PI’s signature: ______________________________ Date: ______________

Chair’s/DA’s signature: ______________________________ Date: ______________

Before you can start working in the lab, you will also need to complete the human subjects, social and behavioral research, CITI course at go.osu.edu/citi.

You will also need to complete a conflict of interest for the university at go.osu.edu/coi.
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<tr>
<th></th>
<th>High School Students</th>
<th>No</th>
<th></th>
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<th>Encouraged to contact the OSUWMC Volunteer Office 293-8653 to pursue volunteer opportunities</th>
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<tr>
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<td>Non-OSU Undergraduate or Graduate Students</td>
<td>No</td>
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<td>3</td>
<td>OSU Undergraduate or Graduate Students</td>
<td>Enrolled in a course requiring shadowing in curriculum</td>
<td>Yes</td>
<td>Yes&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Observation only</td>
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<td>Communication to Office of Student Life from the course or degree program director regarding goals and objectives</td>
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<td>OSU Undergraduate or Graduate Students</td>
<td>Not enrolled in a course requiring shadowing in curriculum</td>
<td>Yes</td>
<td>No</td>
<td>Observation only</td>
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<td>5</td>
<td>US/Canadian Medical Students</td>
<td>Enrolled at LCME-Accredited Medical School</td>
<td>Yes</td>
<td>Yes&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Med 4 equivalent</td>
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<td>Application approved through College of Medicine Office of Medical Education&lt;sup&gt;1&lt;/sup&gt;</td>
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<td>6</td>
<td>International Medical Students</td>
<td>Enrolled at an international medical school</td>
<td>No</td>
<td>Yes</td>
<td>Participate in rotation for credit</td>
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<td>Application approved through College of Medicine Office of Global Health, beginning 2015-16 academic year</td>
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<td>8</td>
<td>International Medical Graduates and Residents</td>
<td>ECFMG certified</td>
<td>Yes</td>
<td>Yes&lt;sup&gt;2&lt;/sup&gt;</td>
<td>Based on PGY level and goals and objectives of rotation</td>
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<td>Endorsed by an OSU Hospital GME training program; application approved by the GME Office</td>
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<td>9</td>
<td>International Medical Graduates and Residents</td>
<td>Not ECFMG certified</td>
<td>Yes</td>
<td>No</td>
<td>Observation only</td>
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<td>Application approved through the Center of Excellence for International Hires and the Office of Global Health</td>
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<td>Visiting Scholars</td>
<td>Yes</td>
<td>No</td>
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<td>Application approved through the Center of Excellence for International Hires and the Office of Global Health</td>
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</tbody>
</table>

**Frequently Used Terms and Acronyms:**
- LCME: Liaison Committee on Medical Education
- ECFMG: Education Commission for Foreign Medical Graduates
- GME: Graduate Medical Education Office

**Superscript explanations:**
1. College of Medicine or GME program, respectively, will provide verification of successful completion of activity. Actual granting of credit is based on the rules and requirements of the student's undergraduate/graduate degree program or home medical school.
2. GME Program or Clinical Department will provide a certificate of completion of the educational experience, if requested. This certificate is not considered a guarantee of competency in any particular field or procedure.
3. Applications for medical students at LCME-accredited medical schools in the US and Canada are processed through the OSU College of Medicine Medical Education Office. Information regarding the application process can be found at the following URL: [http://medicine.osu.edu/students/visitinginternationalstudents/pages/index.aspx](http://medicine.osu.edu/students/visitinginternationalstudents/pages/index.aspx)

**Questions may be forwarded to one of the following applicable offices:**
- Center of Excellence for International Hosting and Hiring 614-688-7643
- Office of Global Health 614-247-8968
- Office of International Affairs 614-292-6101
- College of Medicine Office of Medical Education 614-292-9063
- Graduate Medical Education Office 614-293-7326