

APPENDIX A  
APPLICATION FOR CLINICAL OBSERVERSHIP

**APPLICATION FOR CLINICAL OBSERVERSHIP**  
**DOHENY EYE MEDICAL GROUP – RETINA DIVISION**

RETURN COMPLETED APPLICATION AND SUPPORTING DOCUMENTS TO:  
ATTENTION (CHECK OFF APPROPRIATE MD), DOHENY RETINA INSTITUTE, 1450 SAN PABLO ST., L.A., CA 90033

- Lawrence P. Chong, M.D.
- Dean Elliott, M.D.
- Amani Fawzi, M.D.
- Mark Humayun, M.D.
- Linda Lam, M.D.
- Srinivas Satta, M.D.
- Alexander Walsh, M.D.

NAME: \_\_\_\_\_ DEGREE: \_\_\_\_\_ SOC.SEC.# (U.S.) \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_

COUNTY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ COUNTRY: \_\_\_\_\_

TEL: \_\_\_\_\_ FAX: \_\_\_\_\_ YEAR OF BIRTH: \_\_\_\_\_  
(include country and city codes)

E-MAIL ADDRESS \_\_\_\_\_

MEDICAL SCHOOL: \_\_\_\_\_ YEAR: \_\_\_\_\_

IF FOREIGN GRADUATE, ECFMG # \_\_\_\_\_ DATE: \_\_\_\_\_

LICENSE # \_\_\_\_\_ DATE ISSUED: \_\_\_\_\_

A COPY OF LICENSE RENEWAL FOR CURRENT YEAR MUST ACCOMPANY  
THIS APPLICATION FOR ENROLLMENT

SPECIALTY: \_\_\_\_\_ BOARD CERTIFIED:  Yes  No

AREA OF INTEREST: \_\_\_\_\_  
(Be very specific, and choose one area: glaucoma, cornea, oculoplastics, etc.)

HOSPITAL AFFILIATION(S): \_\_\_\_\_  
\_\_\_\_\_

LANGUAGES SPOKEN: \_\_\_\_\_

IN ORDER OF PREFERENCE, GIVE PREFERRED DATES FOR ARRIVAL:

- 1. \_\_\_\_\_ 2. \_\_\_\_\_
- 3. \_\_\_\_\_ 4. \_\_\_\_\_

**SUPPORTING DOCUMENTS REQUIRED (APPLICATION WILL NOT BE PROCESSED WITHOUT ITEMS 1-3)**

- 1. Copy of Medical License renewal for current year
- 2. Curriculum Vitae
- 3. Current photograph
- 4. Signed "Observership Agreement & Release" form provided by Doheny Retina Institute
- 5. Copy of B-1 or B-2 Visa (required only upon approval of visit. May be submitted to DRI any time prior to arrival)

APPENDIX B  
OBSERVERSHIP AGREEMENT AND RELEASE  
(2-page Appendix)

**DOHENY EYE MEDICAL GROUP**  
**OBSERVERSHIP AGREEMENT AND RELEASE**

I, Dr./Mr./Ms. \_\_\_\_\_ of \_\_\_\_\_

City/State \_\_\_\_\_ Country \_\_\_\_\_ in consideration of being allowed to participate in an observership (the "Observership") at the Doheny Eye Medical Group ("DEMG") do hereby agree that:

1. I understand and agree that my Observership will be for a period of two weeks, from \_\_\_\_\_ to \_\_\_\_\_, and that it shall consist of observing the activities of (department/division/institute:)

\_\_\_\_\_.

At the end of such period, I understand that my Observership will cease and I will no longer be permitted access to DEMG facilities. I further understand and acknowledge that DEMG shall in no way be responsible for monitoring or ensuring my departure from the United States.

2. I agree that I will obtain a B-1 visa or other temporary visitor status from the appropriate authorities for the purpose of participating in my Observership and I agree to maintain and comply with all the requirements of such status for the duration of the Observership.

3. I understand that my Observership is for observation **ONLY**. I will not be permitted to actively participate in patient care or contact, examination, research or other work during the Observership. I understand and agree that my Observership is in no way an offer of or employment by DEMG, and that I shall not receive, nor be entitled to receive, any compensation, reimbursement or remuneration for my participation in my Observership. I further understand and agree that at no time will I be considered or deemed to be an agent, servant or employee of DEMG, I further agree to release DEMG from any and all claims to compensation, reimbursement or remuneration related to my Observership.

4. I understand that I will be observing the activities at a major clinical facility and I therefore agree to act appropriately and in a professional, courteous manner during my Observership. I understand and agree that my Observership may be terminated by DEMG at any time, with or without cause.

5. In the event my Observership involves observing direct patient care, I understand that such patients are entitled to confidentiality and I hereby agree not to disclose, discuss or reveal any details about such patients to anyone other than those involved in my Observership with me.

6. Depending on the department, division or institute that I shall be observing, I understand that I may be required to provide proof that I have been tested for tuberculosis within the past twelve (12) months.

7. In the event I shall be participating in observing the activities of a department where there may be airborne pathogens, I hereby agree to release, indemnify and hold harmless

DEMG, including its present and former Trustees, officers, employees and agents from and against any and all losses, expenses, claims, actions, liabilities and judgments (including attorney fees through the appellate levels), which I may have or accrue as a result of or arising out of my contact with such airborne pathogens.

8. In consideration of my being allowed to participate in the Observership, I agree to release, indemnify and hold harmless DEMG, including its present and former Trustees, officers, employees and agents from and against any and all losses, expenses, claims, actions, liabilities and judgments (including attorney fees through the appellate levels), which I may have or accrue as a result of or arising out of my participation in the Observership, whether caused by the negligence, action or inaction of DEMG or otherwise. I also agree that I shall be fully responsible for any and all loss or damage that I inflict upon any person or upon DEMG's facilities during my participation in the Observership. I understand that this release is intended to be as broad and inclusive as is permitted by the laws of the State of California.

IN WITNESS WHEREOF, the undersigned has signed this Observership Agreement on the \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

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Participant (signature)

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Participant (print name)

APPENDIX C  
HIPAA AUTHORIZATION FORM



Doheny Eye  
Centers

A Division of Doheny Eye Medical Group, Inc.

**AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last First Middle

**Authorization for Use/Disclosure of Information:** I voluntarily authorize and direct my health care provider (Please insert name of provider)

\_\_\_\_\_ to use or disclose my health information during the term of this Authorization to the recipient that I have identified below.

**Recipient:** Student or Physician Observer: \_\_\_\_\_  
(name of Clinical Observer)

**Purpose:** I understand that the specific purpose of this Authorization is to convey my authorization to have a student observer in the exam room and permit discussion of clinical observations between the attending physician and the student.

(Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization)

**Information to be disclosed:** This authorization permits the above provider to disclose the following medical records:

- All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.<sup>1</sup>

<sup>1</sup> NOTE: This Authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law, or mental health records that are protected by the Lanterman-Petris-Short Act.



APPENDIX D  
PROOF OF COMPLETION OF OBSERVERSHIP

April 4, 2008

Name & Address

TO WHOM IT MAY CONCERN:

This letter confirms that \_\_\_\_\_(name) has completed a clinical observership at Doheny Retina Institute at the Keck School of Medicine of the University of Southern California in Los Angeles, California. The observership took place between the dates of \_\_\_\_\_(arrival date) and \_\_\_\_\_(departure date).

Questions concerning this letter may be directed to \_\_\_\_\_(name of Clinical Administrative Assistant) at \_\_\_\_\_(telephone number of CAA).

Sincerely,

<<Name of Sponsoring Faculty Member>>

<<Title of Sponsoring Faculty Member>>