SCOPE | STUDENT CLINICAL OBSERVATION AND PROFESSIONAL EXPLORATION

APPLICATION

Chesapeake Regional Healthcare (CRH) SCOPE Observation Experiences – Operating Room enables individuals to observe the daily activities of a sponsoring CRH staff member. (GAP YEAR applicants are responsible for ascertaining a sponsor and determining an agreed-upon schedule for observation. Designated sponsor signature is required.)

This application must be completed, and copies of all required documents must be returned to CRH Workforce Health via email to **NonEmployee@ChesapeakeRegional.com** at least two weeks before the observation start date. Incomplete or illegible information will delay the process and could extend the applicant's start date. Contact the CRH Workforce Health department with questions at **757-312-4242**.

OBSERVER INFORMATION - Please print legibly or type.

FIRST NAME: _____ **LAST NAME:** _____

ADDRESS: _____
Street City State Zip Code

DATE OF BIRTH: _____ **PRIMARY PHONE #:** _____ **SECONDARY PHONE #:** _____

EMAIL ADDRESS: _____

Are you a current volunteer or CRH employee? Yes ☐ No ☐ If yes, contact Sandra Sherry, April Murray, OR Management.

Are you 18 years or older? Yes ☐ No ☐ If no, the contact information of a parent/guardian is required.

PARENT/GUARDIAN NAME: _____ **PRIMARY PHONE#:** _____

FIRST NAME: _____ **LAST NAME:** _____

ADDRESS: _____
Street City State Zip Code

OBSERVATIONAL PROGRAM APPLYING FOR – Please check applicable program below.

REASON FOR APPLYING

TELL US ABOUT YOURSELF

IMMUNIZATIONS	COMPLETION DATE	EXPIRATION DATE
Negative PPD/TB Screening: administered within the last year		
Influenza "Flu": administered for the current season		
Varicella: 2 vaccines or positive titer		

OBSERVER: I agree to comply with the scope of activities granted and shall follow all CRH policies, bylaws, rules, regulations, standards of conduct and all other CRH guidelines during my authorized SCOPE operating room experience.

OBSERVER SIGNATURE: _____ **DATE:** _____

PARENT/GUARDIAN SIGNATURE (if under 18 years old): _____ **DATE:** _____

CRH GAP SPONSOR: I agree to serve as sponsor for the above-named individual and assume responsibility for their actions during the authorized SCOPE operating room experience observation experience at Chesapeake Regional Healthcare. I understand that the observing student may not provide any care or activity as part of the observation and that it is my responsibility to accompany them at all times.

CRH GAP SPONSOR NAME PRINTED: _____ **DATE:** _____

CRH GAP SPONSOR SIGNATURE: _____ **DATE:** _____

CRH GAP SPONSOR EMAIL: _____

CRH GAP SPONSOR PRIMARY PHONE #: _____ **CRH GAP SPONSOR SECONDARY PHONE #:** _____

CRH WORKFORCE HEALTH APPROVAL: _____ **APPROVAL DATE:** _____