Observer Acknowledgment

I, ______________________________, have asked the George Washington University and/or Hospital to permit me to observe certain patient care activities. I understand that I am neither an independent contractor nor employee of The George Washington University or The George Washington University Hospital and, as such, will not be provided with any benefits whatsoever, including professional liability insurance, compensation, workers compensation or disability coverage, related to my activities as an observer. I understand that I may not record patient care or other activities by any means or method and that I may not receive or document any identifying information received as a result of my observation. I understand that I will not participate in any patient care activities and that any patient, the University, the Hospital, physician or allied health professional staff may request that I be excused from my observation of patient care. I understand that my ability to observe may be revoked at any time, and I agree to voluntarily leave the premises immediately on request. I have provided evidence that I am covered by health insurance, an acknowledge that I am responsible for any treatment that I may receive if I am injured or exposed to any infectious agent or harm as a result of my observation activities hereunder.

I understand that I may come in contact with, or be provided with, confidential or proprietary information as a result of my observation or patient care hereunder. Therefore, I agree that I will not now or at any time in the future, without prior written consent of The George Washington University or Universal Health Services either directly or indirectly divulge, disclose, or communicate in any manner whatsoever to any person not employed or affiliated with the University: (a) any confidential information, including but not limited to, patient information and information regarding quality assurance, risk management, and peer review activities; and (b) any confidential or proprietary information concerning any matters affecting or relating to the business or operations or future plans of the Hospital or the University, or any of its affiliates, including, but not limited to, Hospital or University policies, procedures, rules, regulations, and protocols. I understand that this prohibition extends to, but is not limited to, divulging such information for the purpose of acting as a witness, reviewer, or consultant on behalf of a plaintiff or an attorney acting on behalf of a plaintiff, in a claim or action against the university or Hospital or any of its affiliates or health professionals. This document, however, shall not prohibit or restrict any such divulgence, disclosure or communication made pursuant to an order of a court of competent jurisdiction or otherwise required by law, including testimony or other sworn statements or activities pursuant to lawful process or subpoena. I further agree that in the event I breach this confidentiality requirement, and without limiting the right of the University or Hospital to seek any other remedy or right to which it may be entitled under law, I consent to injunctive relief in favor of the University and Hospital.

______________ ______________________________

Date Signature

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Witness