

NEXS Medical

Clinic Observation Application Packet

1. Observer Information

Full Name: _____

Date of Birth: _____ Phone: _____

Email Address: _____

Address: _____

City: _____ State: _____ ZIP: _____

2. School Affiliation (if applicable)

School Name: _____

Major/Program: _____

Instructor Name (if applicable): _____

Requested Observation Dates: _____

Total Hours Requested: _____

Purpose of Observation (e.g., career exploration, class requirement):

3. Emergency Contact

Name: _____ Relationship: _____

Phone: _____ Alternate: _____

4. HIPAA Confidentiality Agreement

I acknowledge that during my observation I may see or hear confidential patient information. I agree to maintain confidentiality at all times, will not disclose patient information, and understand that violation of this agreement may result in termination of my observation privileges.

Observer Signature: _____ Date: _____

5. Liability Waiver

I understand that by participating in this observation experience, I am voluntarily assuming any risks associated with it. I release NEXS Medical, its staff, and affiliated entities from any liability in the event of an accident or injury during my observation.

Observer Signature: _____ Date: _____

6. Immunization Verification (Attach Proof)

- COVID-19 Vaccine
- TB Test (within past year)
- Flu Shot (current season)

- MMR
- Hepatitis B
- Varicella
- Tdap

7. Parent/Guardian Consent (If under 18)

Parent/Guardian Name: _____

Signature: _____ Date: _____