

**Boston Medical Center
Observer Application**

Personal Information:

Name: _____
(Last Name) (First Name)

Home Address: _____

Telephone: (HM) _____ (Other) _____

Date of Birth: _____ Social Security Number - -
Company/Education Institution: _____

Sponsor Request:

Sponsors Department: _____

Dates of observation From _____ To _____

Observship
Objectives: _____

Sponsors Name: _____

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Attestation: The observer _____(name) will act only in the role of an observer.

Chief of Service Date: _____

I have read the Boston Medical Center policy on Observers and agree to abide by its requirements. I have also enclosed the paperwork required by the policy.

Director, Clinical Area Date: _____

Observer Date: _____