PATIENT AUTHORIZATION FOR STUDENT OBSERVATION

□ BON SECOURS MEDICAL GROUP OR □ BON SECOURS HEALTHSOURCE participates in clinical education programs with area colleges and universities to give students engaged in a course of study related to a medical career; including nursing students, medical students, interns and residents ("students") experience in clinical practice. Your physician has agreed to permit such students to observe and participate in his/her patient care activities, including, where appropriate, providing medical care to patients under the physician's direct supervision.

By signing below you agree to permit the students working in your physician's office to observe and participate in your medical care during your appointment today, including, where appropriate, providing direct medical care to you under your physician's direct supervision. You agree that you have been given the opportunity to refuse to give such consent and that you may withdraw your consent at any time during your appointment.

____

Patient Name

______________________________________ Date:______________ Time:___________

Patient Signature

____

Witness Signature

IF PATIENT IS UNABLE TO CONSENT OR IS A MINOR COMPLETE THE FOLLOWING:

This patient, whose name is written about, is a minor,____years of age or is otherwise unable to consent to and execute this document for the following reason:

I hereby execute this document on the patient's behalf. I have read and fully understand each part of this document. I represent and verify that I am authorized to execute this document on behalf of the patient named above. I understand that I am entitled to receive a signed copy of this document.

______________________________________ ______________________________________

Signature of parent of minor patient, custodial parent, guardian, or legal representative

Relationship to patient

Date: ________________________________ Time:______________________________

____

Witness Signature