CERTIFICATION FOR CLINICAL OBSERVER TO BECOME AN EXCHANGE VISITOR PROGRAM PARTICIPANT SUPPLEMENT TO FORM DS-2019

This certification is required for each physician trained outside the U.S. who will be observing patient care provided in any UK HealthCare hospital or facility by participating in a clinical observership program at the University of Kentucky. Please provide original signatures in all cases.

Attach this Certification statement to the Request for University of Kentucky to Sponsor a J-1 Exchange Visitor for both new and extension requests.

CLINICAL OBSERVER'S NAME ______________________________

will pursue a clinical observership program hosted by : ______________________________

Sponsoring Physicians Name

In accordance with 22 Code of Federal Regulations 62.27(c)(1)(ii) and in support of the issuance of the Certificate of Eligibility (DS-2019) for Exchange Visitor status in P-1-01254, I understand I am responsible for for maintaining and abiding by the following requirements and that failure to do so may result in the removal of my J-1 sponsorship by termination of the DS-2019 as reported to the State Department.
:

A. The program in which I will participate is predominantly involved with observation.

B. I will comply with the Observers at UK HealthCare Policy, A01-090, which includes, but is not limited to, a prohibition on direct patient contact.

C. I will **not be given final responsibility for the diagnosis and treatment** of patients.

D. Any of my activities will conform fully with the Commonwealth of Kentucky licensing requirements and regulations for medical and health care professionals.

E. Any experience gained in this program will not be creditable towards any clinical requirements for medical specialty board certification.

____

Clinical Observer's signature **Date**

Original signatures only:

____

Hosting/Supervising Physician Signature **Telephone number** **Date**

____

Chairman Signature **Department** **Date**

____

Vice Dean for Clinical Affairs, University of Kentucky, College of Medicine Signature **Date**

November 13, 2015

UK HealthCare
Office of Observation and Learning Experience
800 Rose Street
N102

To Whom It May Concern:

I am writing to acknowledge the supervisory responsibilities for foreign medical graduate, ____, who will be an observer in the Department of Internal Medicine, Division of _________________________________ from start date _________________ to end date ____________________. I have read, understand, and will comply with the "*Responsibilities of the Sponsoring Department*" as outlined in the Observers at UK HealthCare Policy, # A01-090, which includes, but is not limited to, a prohibition on direct patient contact. Either I or my designee shall accompany ____ at all times. ______________________________________ will not be given final responsibility for the diagnosis and treatment of patients. Any experience gained through this observership will not be creditable toward any clinical requirements for medical specialty board certification.

____

Printed Name Host Faculty | Signature of Host Faculty | Date

____

Printed Name Division Chief | Signature of Division Chief | Date

____

Printed Name Dept. Chair | Signature of Dept. Chair | Date

I ____ have read the above statements, as well as Observers at UK HealthCare Policy, # A01-090. I understand and will comply with the responsibilities, behavior, and access as outlined in the Policy.

____

Signature | Date