

Observer Form

Observer Name: _____
(Legal Last Name) (Legal First Name)

Home Address: _____

Telephone: (domestic) _____ (international) _____

Date of Birth (mm/dd/yyyy): _____ Email Address: _____

Company/Education Institution: _____

Observer Attestation: I understand BMC shall not be required to provide verification that I observed.

Signature of Observer Date

Sponsor Information:

Sponsor's Department: _____

Dates of observation: From _____ To _____

Purpose of Observation:

Sponsor Attestation: The observer named above will act only in the role of an observer. BMC shall not be required to provide verification. I have read the policy on observers and agree to abide by its requirements. I have also enclosed the paperwork required by the policy. I have verified the identity of the observer against a government or state issued picture ID.

Printed name of Sponsor Signature Date

Inpatient: _____
Name of Patient Care Area Mgr. Signature Date

Outpatient: _____
Name of Administrative Dir. Signature Date