



DHR Health

Student Affairs

2025 International Observer Application

DHR Health Observer Program is an informal shadowing experience that enables applicants to observe alongside a DHR Health employee or member of the medical staff. Participation as an observer does not constitute medical education, training leading to academic credit, licensure or board certification. Applicant is responsible for securing sponsorship as DHR Health does not provide placement. Applicant is encouraged to visit www.dhrhealth.com for listing of affiliated providers and clinics.

Eligibility and Requirements

- Applicant must be at least 16 years of age. Parent or guardian consent will be required.
- Applicant must provide proof of English language proficiency; score must be no more than two years old from date of submission. Refer to list of approved exams and minimum score below:

Test of English as a Foreign Language (TOEFL)	80
Occupational English Test (OET) **per section	350
American Examination of the International English Language Testing System (IELTS)	6.2

***English proficiency exemptions available to applicants who are U.S. citizens or U.S. permanent residents*

Required immunizations and documentation

- **Hepatitis B** (Positive titer with IGG levels)
- **MMR** (Positive titer with IGG levels)
- **Varicella** (Positive titer with IGG levels)
- **TDAP** (received within the last **10 years**)
- **Tuberculosis (TB)** (Negative-PPD/QuantIFERON TB Gold (12mo) or chest x-ray received within **6** months)
- **Seasonal Influenza** (If applying between October thru April)

(All records must be fully validated per U.S.-CDC standards. Signed or stamped from an appropriate medical source)

- **N95 Respiratory Fit Test** (acceptable masks: 3M 1860, 3M 1870+ or Haylard N95 received within the past **12** months)
- **Government issued photo ID**
- **Student ID** (Medical student applicants only)

Administrative Fees

A non-refundable administrative and criminal background check fee must be submitted via money order or cashier’s check addressed to DHR Health. **Applications will not be processed until fees have been received.**

	International Medical Student	International Medical Graduate
Administrative Fee	\$100	\$200
Proof of enrollment required?	YES	N/A
Criminal background Fee	\$50	\$150
Total	\$150	\$350

The complete application and **printed copies** of all requested items must be submitted, or mailed to the address shown below, **60-90 days** prior to expected start date. Email submissions are not acceptable.

102 Paseo Del Prado
Edinburg, TX—78539



DHR Health

Student Affairs

Print clearly

International Observer Application		
Application must be submitted 60-90 days prior to expected start.		
Applicant Information		
Check applicable box <input type="checkbox"/> International Medical Student <input type="checkbox"/> International Medical Graduate <input type="checkbox"/> Other _____		
Last Name	First Name	Middle Name
Street Address		
City:	State:	Zip Code:
Email Address:	Phone Number:	
Emergency Contact Information Name: Contact Number:		
Please select a schedule that aligns with you and your DHR Sponsor – 30 day maximum		
Preferred Start Date:	Preferred End Date:	Circle Days of Rotations:
____/____/____	____/____/____	M T W TH F S SU
Sponsor Name: _____		
Sponsor Signature: _____		
Sponsor Employee Number: _____	Date: _____	
By signing, I certify I am an active DHR Health employee or member of the medical staff who has willingly agreed to provide oversight for the above applicant.		
102 Paseo Del Prado Edinburg, TX—78539 StudentAffairs@dhr-rgv.com		



DHR Health Clinician/ Employee Responsibilities & Scope of Practice

It is the policy of DHR Health to promote learning at our facilities with the goal of increasing the number of medical and healthcare professionals in the communities we serve. All such observations must be done under the sponsorship and supervision of a DHR Health employee or member of the medical staff.

Participation must be done in a manner that does not compromise or interfere with patient care; appropriate confidentiality must be maintained at all times.

Supervising Clinician/Employee Responsibilities:

- Remind the participant of their obligation under the confidentiality statement and HIPAA regulations.
- Minimize the amount of PHI provided or exposed to the participant.
- Arrange for a short orientation session to review expectations of participant.
- Supervising clinician/employee will be responsible for their participant during their time at DHR Health. An alternate person should be declared in advance to supervise the participant if the sponsor/supervisor is called away.
- Supervising clinician/employee will notify the *clinic/department manager, floor supervisor or house supervisor* of the participant's presence and the dates when they will be at the facility.
- Supervising clinician/employee must introduce participant as an "Observer" and must request the *patient's consent* to having the observer present during the patient's examination. Only after a patient consents, may the observer participate.
- Observer experiences should not surpass 30 days.
- Academic credit **WILL NOT** be granted.
- The individual observing **WILL NOT** be involved nor, assist, or participate in any patient care activities.
- Violation of the aforementioned observer responsibilities is grounds for immediate dismissal.



DHR Health

Student Affairs

DHR Clinician/Employee Responsibilities & Applicant Scope of Practice Agreement Form

MUST BE COMPLETELY FILLED OUT

Sponsor Printed Name: _____

Sponsor Employee Number: _____

Sponsor Email / Phone: _____

Sponsor Signature: _____

Applicant Printed Name: _____

Applicant Signature: _____

Facility: _____

Administrator: _____

Administrator Email/Phone: _____

Administrator Signature: _____



DHR Health

Student Affairs

Sponsor Acknowledgement

To the Student Affairs Department at DHR Health,

I am writing to inform you that I have voluntarily offered the below applicant the opportunity to participate in an observer experience at DHR Health. The applicant will be under my mentorship and direct supervision.

This experience will be available to the applicant for the dates listed on application. This is an unpaid and unfunded observer experience, during which the primary purpose is observational as to enhance insight and understanding of the various healthcare career pathways.

As required by DHR Health, this applicant will ***only observe*** while under my supervision.

I understand that the observer will have no hands-on patient contact, nor will they be responsible for patient care activities.

I further understand that the observer will dress in professional attire at all times while under my supervision. I understand that the observer must not attempt to pass themselves off as a medical professional.

Sponsor Printed Name: _____

Sponsor Signature: _____



General Guidelines and Agreements

Initial Below

1. Applicant acknowledges they will remain with supervising clinician/employee at **all times** while in the assigned DHR department or assigned unit/clinic. If supervising clinician or employee is unavailable, a named designee will supervise or participation may be rescheduled.
2. Applicant acknowledges that their participation will be restricted to their designated sites.
3. Applicant acknowledges to dress in a professional manner. Jeans, shorts, spandex, cropped tops, and leggings **are unacceptable**; footwear is limited to closed shoes. Attire shall be clean, moderate in style, and appropriate for the designated work area; medical attire (scrubs) is not allowed unless required by the procedural site.
4. Applicant acknowledges to always be clearly identifiable by using their respective DHR assigned observer badge; this is to be worn at all times above the waist with picture side out (**Policy#: HR-1026**).
5. Applicant acknowledges that cell phones are not permitted during their observation period.
6. Applicant acknowledges that the supervising clinician/employee must notify patient(s) that an observer experience is taking place and ask for the patient's consent to having the applicant present during their examination or care.
7. Applicant acknowledges that their participation as an observer does not constitute hands-on experience. Applicant acknowledges that they may not participate in any direct patient contact, defined as: physical touching; talking with; performing a medical history and/or examination; counseling (patients or patient's family/friends); assisting in surgery or any other procedure, or otherwise interacting with patients.
8. Applicant acknowledges that they may not make medical notations or changes to patient chart. No written information will be taken from DHR property or patient rooms.
9. Applicant acknowledges that failure to comply with hospitals and medical staff policies and procedures will result in termination of the participant's experience.
10. Applicant acknowledges that it is policy of DHR to promote an environment free from any form of harassment and discrimination.
11. Applicant acknowledges that all assigned DHR property such as badge(s) and parking permit(s), must be returned *upon* completion of experience at DHR Health. A \$20.00 reimbursement fee per lost, stolen or destroyed property will be required.

Applicant Printed Name: _____

Applicant Signature: _____



Confidentiality and Privacy of Patient Information

Dear Applicant,

As an Observer who is participating at DHR Health (or associate clinics and facilities), you have an ethical and legal duty to keep patient information confidential. Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) allows health care providers to use and disclose patient information in limited circumstances, such as treatment, but most of the time it is necessary for the patient to consent to have their information shared or disclosed. Allowing a participant to observe an encounter between provider and a patient requires patient authorization. Failure to maintain the confidentiality of patient information as required by HIPAA is considered a violation of the law and may have legal repercussions.

I, [REDACTED] (print full name), understand that DHR Health considers it the ethical responsibility of each employee, contracted employee, learner, volunteer or observer to respect and maintain the confidentiality of patients, physicians and fellow staff members, as well as organizational information. Therefore, it is expected that I will be worthy of the trust given to me and that I will perform my duties to the best of my ability with intelligence, courtesy, tact, and cheerfulness – the *“Renaissance Difference.”*

I acknowledge that access to confidential information is for the purpose of gaining insight to a respective field within healthcare and for no other purpose. I understand that confidential information is protected in every form, such as: written records, correspondence, oral communications, and computer programs and applications. Medical records are legal documents and contain confidential information. I understand that all information regarding patients and their health care is strictly confidential. Information of a privilege nature is to be shared only with authorized parties and such discussions should be held in a private location. Unauthorized disclosure of medical record information could result in legal action against the hospital and observer who violates the patient’s rights.

I understand that any violation of the confidentiality policy may result in corrective action, including dismissal or termination of observer participation. I agree that my obligations under this agreement continue after my observer participation ends.

Applicant Printed Name: _____

Applicant Signature: _____



Release and Waiver of Liability

Read this waiver carefully before you sign.

This Waiver of Liability (the "Waiver") executed on this [redacted] day of [redacted], 2025 by [redacted] (the "Observer's" name) in favor of Doctors Hospital at Renaissance ("DHR"). In consideration of DHR allowing me to be an Observer at the hospital, I hereby freely and voluntarily, without duress execute this Waiver under the following terms:

1. **Status:** I, the Observer, understand and agree that as an observer, I am not an employee of DHR, and I will not be eligible for, entitled to, or receive compensation and benefits available to employees of DHR.
2. **Waiver and Release:** I, the Observer, release and forever discharge and hold harmless DHR from any and all liability, claims, and demands of whatever kind of nature, either in law or in equity, which arise or may hereafter arise from my participation with DHR. I understand and agree that this Waiver discharges DHR from any liability or claim that I, the Observer, may have against DHR with respect to bodily injury, personal injury, illness, death, or property damage that may result from participation on a DHR site.
3. **Insurance:** I, the Observer, understand and agree that I am not and will not be covered by workers' compensation insurance or any other form of insurance maintained by DHR for its employees.
4. **Assumption of Risk:** I understand, acknowledge and assume all inherent risks associated with my participation with DHR. I hereby expressly and specifically assume the risk of injury or harm from my participation, and I hereby release DHR from any and all liability for injury, illness, death, or property damage resulting from my participation as an Observer while at DHR.
5. **Scope and Enforceability:** I expressly agree that this Waiver is intended to be as broad and inclusive as permitted by the laws of the State of Texas and that this Waiver shall be governed by and interpreted in accordance with the laws in the State of Texas. I agree that in the event that any clause or provision of this Waiver shall be held to be invalid by any court of competent jurisdiction, the validity of such clause or provision shall not otherwise affect the remaining provisions of this Waiver, which shall continue to be enforceable.

BY SIGNING BELOW, I ACKNOWLEDGE AND REPRESENT THAT I HAVE CAREFULLY READ AND REVIEWED THIS RELEASE AND WAIVER OF LIABILITY, AND FULLY UNDERSTAND ITS CONTENTS. I HEREBY EXPRESS MY UNDERSTANDING AND INTENT TO ENTER INTO THIS RELEASE AND WAIVER OF LIABILITY WILLING AND VOLUNTARILY.

Applicant Printed Name: _____

Applicant Signature: _____

If applicant is under the age of 18, a parent/guardian must read and sign this Release and Waiver of Liability Form.

Parent or Guardian _____

Date: _____



DHR Health

Student Affairs

Learner Acknowledgements

By signing below I acknowledge the completion of DHR Health's Learner acknowledgments presented to me via the QR code shown below.

Initial Below:

- ___ 1. Learner Acknowledgment-Injury, Needle-Stick, or Blood Body Fluid-Exposure Reporting
- ___ 2. Learner Acknowledgment-Accident or Incident Reporting
- ___ 3. Learner Acknowledgment-HIPAA Basics
- ___ 4. Learner Acknowledgment-Harassments in the learner setting
- ___ 5. Parking Acknowledgment
- ___ 6. Criminal Background Disclosure and Release

Learner Acknowledgements



Parking Acknowledgements



CBC Disclosure & Release



Applicant Printed Name: _____

Applicant Signature: _____