

**ALVIN COMMUNITY COLLEGE
DIAGNOSTIC CARDIOVASCULAR SONOGRAPHY
PROFESSIONAL OBSERVATION FORM**

Student Name: _____ Date: _____

Dear Prospective Student:

Please use this form to schedule and document your professional observation. An observation is **required** for admittance to the DCVS Program. Please be courteous and professional while in the class, lab, or clinical sites. Dress professionally. **Absolutely no jeans or shorts are to be worn by either males or females when visiting the hospitals!** **Return this form with your completed application.** **Minimum requirement: 4 hours observation required in EACH area: Adult Echo, Pedi-Echo and Vascular (total 12 hours required).**

YOU MAY ACCOMPLISH YOUR PROFESSIONAL OBSERVATION BY ONE OF THE THREE OPTIONS

___ **OPTION #1** - visit the classroom during lecture or lab for Adult Echo, Pedi-Echo and Vascular Technology. (Classes and lab are approximately 4 hours in length. Feel free to be a volunteer for a scan) Call the DCVS Program Secretary to schedule your visit. (281-756-5625)

Verification of Visit:

Student visited Adult Echo Lecture/Lab _____ on _____ (date) _____ (hours)
Student visited Pedi-Echo Lecture/Lab _____ on _____ (date) _____ (hours)
Student visited Vascular Lecture/Lab _____ on _____ (date) _____ (hours)

Instructor's Signature(s) _____

___ **OPTION #2** - Visit the clinical site with the clinical director during a regularly scheduled clinical day for both Echocardiography and Vascular Technology. (Plan to spend at least 4-hours in each area.) Call the clinical director to schedule. (Lynne Bruner 281-756-5651)

Verification of Visit: _____

Student visited _____ on _____
(hospital(s)/clinical(s) (date)

Student was able to observe: _____

Clinical Director's Signature: _____

___ **OPTION #3** Personal Experiences. This option must be approved by the program director. You are already familiar with the job description and a performance requirement by way of prior observation of these types of procedures as a patient yourself, a family member, or working in a facility where these types of procedures are offered. Please describe your personal experience with Adult Echo, Pedi-Echo, or Vascular Technology. Personal experiences must be signed by sonographer and total at least 12 hours.

Sonographer Signature: _____ **Date:** _____

Please allow the prospective student to view at least one (1) procedure in each of the following categories if possible.

I. Non-invasive procedures: _____ ECG _____ Stress Testing _____ Holter Monitoring
_____ Cardiac Ultrasound _____ Vascular Ultrasound _____ Other, please specify: _____
_____ Pediatric Echocardiogram

II. Invasive procedures: _____ TEE _____ DSE _____ Treadmill Stress Echo
_____ Other, please specify: _____

III. Non-Imaging procedures: _____ Arterial Doppler _____ Segmental Pressures _____ Arterial Plethysmography
_____ Other, please specify: _____

Sonographer Signature: _____ **Date:** _____

Please sign HIPAA agreement **on back** and return this form with the application to the DCVS Program at Alvin Community College.

ALVIN COMMUNITY COLLEGE
DIAGNOSTIC CARDIOVASCULAR SONOGRAPHY PROGRAM
CONFIDENTIALITY STATEMENT – PROFESSIONAL OBSERVATION
HEALTH INFORMATION ACCOUNTABILITY AND PORTABILITY ACT (HIPAA)

I understand that information about the hospitals affiliated with Alvin Community College, its patients, employees, or suppliers is confidential and that I will not discuss patient information with anyone other than my preceptor and/or the hospital staff directly involved in the patient's care. I understand that results of HIV testing on patients and employees will be known to certain physicians and direct care givers and I will keep this information in strictest of confidence. When in doubt as to whether certain information is or is not confidential, prudence dictates that no disclosure be provided without first clearly establishing that such disclosure has been authorized by the department manager.

The medical record is a confidential, legal document and, as such, all information contained therein or disclosed to me shall be treated as confidential and not discussed or repeated without authorization from the patient or responsible party. I understand that violations of the confidential nature of the medical record, the Release of Information Policy of the Hospital, or the security regulations of the Medical Records Department may result in either civil or criminal sanction(s). Civil penalties are fines of up to \$100 for each violation for each requirement per individual. Criminal penalties for "wrongful disclosure" can include not only large fines, but also jail time. The criminal penalties increase as the seriousness of the offense increases. These penalties can be as high as \$250,000 and prison sentences of up to 10 years. Knowingly releasing patient information can result in a one-year jail sentence and up to a \$150,000 fine. Releasing patient information with harmful intent, or selling the information, can lead to a 10-year jail sentence and a \$150,000 fine.

Your signature below indicates that you have been informed of the Health Insurance Portability and Accountability Act (HIPAA) regulations, and acknowledge the consequences of violation of those regulations.

Applicant Signature

Date

Clinical Instructor

Date