Shirley Ryan Abilitylab

Observership Application

Applicant Information

First Name: First Name Last Name: Last Name

Email: Email Telephone: Telephone

US Citizen: ☐ Yes ☐ No

Mailing Address

Street Address: Number and Street Address

City: City

State: State (If applicable)

Country: Country

Zip Code: Zip Code

Emergency Contact

Name: Name Relationship: Relationship

Email: Email Telephone: Telephone

Academic History

Institution Name	City, State, Country	Dates Attended From/To (month/day/year)	Major Field of Study	Degree	Date Awarded or Expected (month/day/year)

Certification/Licensure

Certification / Licensure Type	Date Granted (month/day/year)	Granting Agency

Employment and Training Experience

Dates From/To (month/day/year)	Type of Experience (i.e.: Teaching Intern, Military, Residency, Practice, Etc.)	Institution	City, State, Country

2 Professional References

Please provide contact information for two professionals who can attest to your ability.

Reference 1:

First Name: First Name Relationship: Relationship

Last Name: Last Name Title: Title

Email: Email Telephone: Telephone

How long have they known you?: # Years Address: Address

Reference 2:

First Name: First Name Relationship: Relationship

Last Name: Last Name Title: Title

Email: Email Telephone: Telephone

How long have they known you?: # Years Address: Address

Statement of Intent

In the area below please identify your goals, objectives, expectations and areas of interest as a Rehabilitation Observer. Attach additional sheets as necessary.

[Type your statement here]

Proposed Dates for your Observership

Application must be received at least 3 months before your proposed dates. We will make every attempt to accommodate your preferences but cannot guarantee these dates as it based on our clinicians' availability and schedules as well. Please remember, observerships are no longer than 2 weeks in length.

First Choice: Anticipated Date of Arrival and Departure

Second Choice: Anticipated Date of Arrival and Departure

Third Choice: Anticipated Date of Arrival and Departure

Acknowledgements

Please read the following statements carefully before signing your application.

I understand that all application material submitted to the Shirley Ryan AbilityLab becomes the property of Shirley Ryan AbilityLab and is not returnable.

I understand that the information submitted herein will be relied upon by the Shirley Ryan AbilityLab to determine my status for eligibility as Observer. I authorize Shirley Ryan AbilityLab to verify the information I have provided. I understand that any omission of requested data may jeopardize my consideration for the Rehabilitation Observer program. I agree to notify the proper Shirley Ryan AbilityLab employees to any changes in the information provided. I understand that the scope and privileges of the program are listed in the Observership Program Application Checklist document, Section II, and no modifications are allowed in the program.

COVID Symptoms and/or Diagnosis: I understand that Observers are required to self-screen for symptoms prior to being on-site at any SRAlab facility. I understand that if I am exhibiting COVID symptoms, I am prohibited from entering any SRAlab facility until I receive negative test results. I understand that if I am diagnosed as having COVID, even in the absence of a positive test result, I am prohibited from entering any SRAlab facility until I am either medically cleared by a licensed healthcare provider or satisfy the requirements of CDC's Return to Work Healthcare Guidance. I acknowledge that SRAlab retains the right to request and receive proof of negative test results, medical clearance by a licensed healthcare provider, or satisfaction of the requirements of CDC's Return to Work Healthcare Guidance at any time, including prior to allowing my return to any SRAlab facility. I understand I am required to be in receipt of such proof and attests that it will be able to provide such proof upon request. I agree that an inability to provide such proof upon request will result in being barred from physically entering any SRAlab facility until such time as the proof is provided. I agree that ongoing failure to comply with a request by SRAlab for such proof will result in termination of the Agreement for cause.

I certify that the information in the application is complete and correct to the best of my knowledge and belief. I acknowledge the submission of any false information is grounds for rejection of my application or termination of my Observership.

Signature: Date:

Release of Information

I release from liability and from any restrictions as to confidentiality or privacy of all hospitals, schools, physicians, clinicians, employers, individuals, agencies or organizations that provide information about me at the request of the Shirley Ryan AbilityLab or its agents.

Signature: Date: