This Periop Invitee Agreement Form must be signed and submitted to the HUP Director of Perioperative Services prior to schedule start time of the surgical procedure, and a copy must be placed in the Operating Room Log.

PeriOp Invitee Agreement Form

This PeriOp Invitee Agreement Form (Agreement") between The Trustees of the University of Pennsylvania, as owner and operator of the Hospital of the University of Pennsylvania (HUP) and ____ (*Individual's name*) (Invitee) specifies the terms and conditions under which HUP will permit the Invitee to be present in the PeriOp-operating room area and/or a recovery room in which a patient is present.

1. **Location, Time, and Purpose.** Invitee is permitted to be present in PeriOp/Operating Room/Recovery Room (*choose which ever applies*) (PeriOp/OR/Recovery Room) on ____________________, 20___ (*specify the date*), during the surgery and/or the recovery of the following patient: ____ (*insert name and medical record number of patient*). Invitee will remain only in the approved area and will leave immediately upon the request of any hospital staff. Invitee's presence has been approved for the purpose of: (*clearly and precisely state the reason for the Invitee is permitted in the PeriOp/OR/Recovery Room*) _______________________________________
____
HUP may withdraw its approval at any time for any reason.

2. **Confidentiality.** Invitee will have access to patient information and HUP information of a confidential and/or proprietary nature, including but not limited to patient medical information, patient demographic information, and information regarding HUP's provision of health care and practices (Confidential Information). Invitee will (a) secure and protect the Confidential Information consistent with standards and laws applying to the security and protection of patient information. Including, but not limited to any such regulations under Health Insurance Portability and Accountability Act of 1986, and any applicable state privacy and security legislation or regulations, (b) will not use the Confidential Information except to achieve the Purpose under this Agreement, and (c) will not disclose the Confidential Information except to those individuals providing medical care to the patient. This restriction will not apply to Confidential Information the Invitee is required by law, regulation, rule, or court order of any governmental authority to disclose if Invitee first notifies HUP as soon as possible, but in no event less than fifteen (15) days, prior to disclosure, and cooperates with HUP in any response to such required disclosure. In addition, Invitee will immediately inform HUP of any disclosure of Confidential Information, it will return it to HUP or destroy it the sooner end of the procedure or upon HUP's request.

3. **Covenants, Representations, and Warranties**.

a. Invitee covenants that he/she is aware of HUP's safeguards against the introduction of infection and that he/she is not aware that he/she has any infectious disease Invitee represents and warrants that he/she will comply with all safeguards against infection and other hazards.

b. Invitee represents and warrants that he/she will comply with HUP's rules, policies, and procedures.

c. If the Invitee is to participate in the surgery, the Invitee represents and warrants that

he/she received the requisite approval from Medical Affairs and has the appropriate licensure, insurance coverage, qualifications, and competencies to participate, which are: (insert the appropriate licensure, insurance coverage, qualifications, and competencies)
____
____
__________________. Invitee represents and warrants that he/she will not directly or indirectly touch the patient, will in no way interfere with the provision of health care or the individuals in the PeriOp/OR/Recovery Room, will not enter sterile field, the sterile supply area, or the scheduling office, and will not touch any equipment or supplies in the PeriOP/OR/Recovery Room with the exception of the following: (list anything the Invitee may touch, and make sure that each item matches the purpose described in paragraph1 and the competencies paragraph 3(c)). ____
____
____.

d. Invitee represents and warrants that he/she will not photograph, audiotape, videotape, or otherwise record any aspect of the surgical procedure or recovery unless expressly permitted pursuant to a hospital policy.

e. Invitee represents and warrant that he/she will respect the privacy of all patients.

4. **Miscellaneous**. This Agreement will be governed by and construed and enforced in accordance with the laws of the Commonwealth of Pennsylvania. If any provision of this Agreement is rendered invalid or unenforceable by enactment of any applicable statute or ordinance or by any regulations duly promulgated or is made or declared unenforceable by any court of competent jurisdiction, the provision will be deemed stricken from this Agreement and the remainder of the Agreement will remain in fully force and effect. No waiver will be binding unless executed in writing by the party making the waiver. No waiver of any provisions of this Agreement will be deemed or will constitute a waiver of any other provisions, whether or not similar, nor will any waiver constitute a continuing waiver. Neither party may assign this Agreement or any rights hereunder, nor may it delegate any of its duties to be performed hereunder, without the prior written consent of the other party. This Agreement will be binding upon, and will insure to be the benefit of, the parties and their respective legal representative, successors and assigns.

The parties consent to the terms of this Agreement

The Trustees of the University of Pennsylvania
as owner and operator of the Hospital of the University of Pennsylvania

By: ____
(signature)

Printed: _____________________________________
(print name)

Its: ____
(print title)

Invitee

____
(print Invitee's name)

____
(print Invitee's title)

____
(Invitee's affiliation)

____
____
(Invitee's address)

____
(Invitee's signature)

PeriOp Invitee Clinical Screening

Referenced from Department of Health and Human Services
Centers for Disease Control and Prevention

For more information, visit www.flu.gov or call 800-CDC-INFO.
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Do you have any of the following?

Fever	Y	N
Headache	Y	N
Extreme tiredness	Y	N
Dry cough	Y	N
Runny or stuffy nose	Y	N
Muscle aches	Y	N
Sore throat	Y	N
Vomiting	Y	N
Sometimes diarrhea	Y	N

Signature of Invitee____

Date____________________

Revised 1/10