

# Request for Presence of Observer During Childbirth/Medical Procedure

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I, (*patient name*) \_\_\_\_\_, expecting to undergo childbirth/a medical procedure, hereby request the presence of (*observer name*) \_\_\_\_\_ to (*hospital name*) \_\_\_\_\_ during childbirth/the following medical procedure: \_\_\_\_\_.

I have been instructed by the attending physician/health care practitioner concerning standard practices during the childbirth/medical procedure. I hereby release the attending physician/health care practitioner and (*hospital name*) \_\_\_\_\_, their officers, directors, agents, and employees from any liability in the event the presence of the observer during childbirth/medical procedure leads to injury to me or to the observer or to others.

Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM / PM

Signature: \_\_\_\_\_  
(*patient/legal representative*)

If signed by someone other than patient, indicate relationship: \_\_\_\_\_

Print name: \_\_\_\_\_  
(*legal representative*)

Witness: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM / PM

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I, the observer, understand that during the childbirth/medical procedure, the attending physician/health care practitioner and the hospital staff must devote their full attention to the patient. I therefore agree to:

1. Bring to the attention of the attending physician/health care practitioner and the hospital nursing staff any medical problems I have which could interfere with the care of the patient. Such problems might include:
  - Lapse of consciousness problems, such as fainting, epilepsy, narcolepsy, etc.
  - Weak stomach
  - Convulsions
  - Diabetes
  - Heart problems
2. Conform to all rules and regulations of the hospital.

3. Comply with all orders and directions of the attending physician/health care practitioner and hospital nursing staff.
4. Leave the area immediately if considered necessary by the attending physician/health care practitioner or hospital nursing staff.

I have been instructed by the attending physician/health care practitioner concerning standard practices during the childbirth/medical procedure. I understand and agree that the hospital, physicians and other personnel have no duty to me and I hereby release the attending physician/health care practitioner and (*hospital name*) \_\_\_\_\_, their officers, directors, agents, and employees from any liability in the event my presence during the childbirth/medical procedure leads to injury to me or to the patient or to others.

Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM / PM

Signature: \_\_\_\_\_  
(*observer*)

Witness: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM / PM

### **Certificate of Attending Physician / Health Care Practitioner**

I am the attending physician/health care practitioner of the above-named patient. I have conferred with both the patient and the above-named observer, and I believe the patient and the observer understand, and will comply with, the hospital's policies regarding the presence of the observer during the childbirth/medical procedure. It is my medical judgement that the presence of the observer during the childbirth/medical procedure will not compromise the health or safety of the patient, the observer, or others.

Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM / PM

Signature: \_\_\_\_\_  
(*attending health care practitioner*)

**NOTE:** This form should include taglines as required by the Affordable Care Act.  
(See [www.calhospital.org/taglines](http://www.calhospital.org/taglines), for detailed information.)

# Solicitud Para la Presencia de un Observador de un Parto o de un Procedimiento Medico

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Yo, (*nombre del paciente*) \_\_\_\_\_, espero dar a luz o someterme a un procedimiento médico, por la presente solicito la presencia de (*nombre del observador*) \_\_\_\_\_ al (*nombre del hospital*) \_\_\_\_\_ durante el parto o el siguiente procedimiento médico: \_\_\_\_\_.

El médico/integrante del personal médico a cargo me ha explicado la práctica usual durante el parto o procedimiento médico. Por la presente eximo al médico/integrante del personal médico a cargo y al (*nombre del hospital*) \_\_\_\_\_, a sus funcionarios, directores, agentes y empleados de toda responsabilidad en el caso en que la presencia de un observador del parto o procedimiento médico me cause lesiones o cause lesiones al observador o a terceros.

Fecha: \_\_\_\_\_ Hora: \_\_\_\_\_ AM / PM

Firma: \_\_\_\_\_  
(*paciente o representante legal*)

Si no lo firma el paciente, indique la relación con éste: \_\_\_\_\_

Nombre en letra de imprenta: \_\_\_\_\_  
(*representante legal*)

Testigo: \_\_\_\_\_

Fecha: \_\_\_\_\_ Hora: \_\_\_\_\_ AM / PM

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Yo, el Observador, entiendo que durante el parto o el procedimiento médico, el médico/integrante del personal médico a cargo y el personal del hospital deben dedicar su plena atención al paciente. Por lo tanto, acuerdo:

1. Informar al médico/integrante del personal médico a cargo y al personal de enfermería del hospital sobre cualquier problema médico que tenga, que pueda interferir con la atención del paciente. Esos problemas pueden incluir:
  - Problemas de lapsos del conocimiento, por ejemplo desmayos, epilepsia, narcolepsia, etc.
  - Estómago débil
  - Convulsiones
  - Diabetes
  - Problemas cardíacos
2. Cumplir con todas las reglamentaciones y normas del hospital.

3. Cumplir con todas las órdenes e instrucciones del médico/integrante del personal médico a cargo y del personal de enfermería del hospital.
4. Salir inmediatamente de la zona si el médico/integrante del personal médico a cargo o el personal de enfermería lo consideran necesario.

El médico adjunto/médico general me ha proporcionado información acerca de los procedimientos habituales durante el parto o procedimiento médico. Por medio del presente eximo al médico adjunto/médico general y (nombre del hospital) \_\_\_\_\_

\_\_\_\_\_, sus funcionarios, directores, representantes y empleados de toda responsabilidad civil, en caso de que la presencia del observador durante el parto o procedimiento médico dé origen a lesiones en mi persona, en el observador o en terceros.

Fecha: \_\_\_\_\_ Hora: \_\_\_\_\_ AM / PM

Firma: \_\_\_\_\_  
(observador)

Testigo: \_\_\_\_\_

Fecha: \_\_\_\_\_ Hora: \_\_\_\_\_ AM / PM

### **Certificate of Attending Physician / Health Care Practitioner**

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Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM / PM

Signature: \_\_\_\_\_  
(attending health care practitioner)

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