



DIRECTIVE DESPITE OBJECTION



DEPARTMENT: _____ FACILITY: _____

PURPOSE: To notify your supervisor or manager that you have been given a written or oral directive or memorandum to which you have a reasonable and serious objection.

INSTRUCTIONS: Please complete this form clearly or go online to uapd.com, "Member Section" to find the link to this form. You can also fax this form to UAPD's Sacramento Headquarters at (916) 442-3827. One or more physicians and/or providers may complete/sign each form. **Complete and give your supervisor or manager one copy, send one to the UAPD, and keep one copy for your records.** Include the complete name and title of the person(s) making the directive and receiving your objection. Please complete the response section as well as the date and time of their response. If you do not receive a response please note this and submit a copy of the completed form to the next highest level of administration.

SECTION 1: In accordance with my obligations as a health care professional I am objecting to the attached directive/ memorandum. I have notified [redacted] in management of my serious objection.

Date [redacted] Time [redacted]

SECTION 2: Check all applicable concerns:

- Exceeds Scope of Practice
- Inadequate Time to Assess Patient
- Inadequate Staffing to Meet Defined Ratios
- New Patients Transferred or Admitted to Unit w/out Adequate Staff
- Delay in Assessment or Treatment
- Excessive Workload
- Arduous After Hours Coverage (On-Call/MOD/POD)
- Inadequate Resources (i.e. equipment)
- Threat to Health and Safety of staff
- Threat to Health and Safety of employees
- Missed Breaks
- Other _____

Brief Statement of the problem in your own words:

SECTION 3: If the directive stands despite notice of my objection, I will carry out/have carried out the directive to the best of my professional ability, unless I believe that I cannot do so because it would jeopardize my license, because it may harm a patient, or because it would be illegal. However, I hereby give notice to my employer of the above facts and indicate that for the reasons listed, full responsibility for the consequences of this directive must rest with the employer. Copies of this form may be provided to all appropriate state and federal agencies.

Name and Title of Member _____ Date _____

Response of Danagement Official

Name of Supervisor _____ Your Signature _____