APPLICATION FOR MEDICAL STUDENT CLINICAL ROTATION

LEGACY HEALTH

PLEASE RETURN COMPLETED FORM TO: Traci Aul, Medical Education Coordinator, Graduate Medical Education
◆ Mail: 1015 NW 22ndAve, Northrup Bldg. #22, Portland, OR 97210 ◆ Phone: (503) 413-7590 ◆ Fax: (503) 413-7361 ◆ Email: taul@lhs.org

APPLICANT INFORMATION *(all information required for access to Epic/patient medical charts/records)*

Name: _____ **Phone #:** _____
(last) (first) (mi) *(000) 000-0000*

Mailing Address: _____
(street) *(city/state/zip)*

Gender: *M F* (Circle one) **Birthdate:** _____ *(mm/dd/yyyy)* **Soc. Sec. #:** _____ *(last 4-digits required)* **Email:** _____

Emergency Contact: _____ **Phone #:** _____
(000) 000-0000

Home Institution: _____ **Graduation Date:** _____
(mm/dd/yyyy)

Address: _____
(street) *(city/state/zip)*

Residency plans: ☐ ***Internal Medicine*** ***Other:*** _____

Exam Scores: ***USMLE/Comlex Step 1**** _____ ***USMLE/Comlex Step 2 (if taken)**** _____

****a copy of your transcript may be required prior to the first day of an approved rotation***

ROTATION INFORMATION *(only one rotation per student will be approved)*

Rotation Name *(Inpatient Wards/Intensive Care Unit)*		**Legacy Campus** *(Emanuel, Good Samaritan, or No Preference)*	**Requested Dates** *Priority*		**Requested Dates** *Alternate*	
			START	**END**	**START**	**END**
Priority:						
Alternate:						

INSTITUTIONAL INFORMATION *(this section must be completed by the student's Program Director or Dean)*

This student's home institution is responsible for verifying and maintaining evidence and documentation of the administrative requirements for each student as established under Oregon Administrative Rules 409-030-0100 and will provide Legacy Health with documentation of the below requirements upon request.

	Circle One	
This student has documented proof of receipt of vaccine or documented immunity via titer or valid history of disease, or a record from the Oregon ALERT Immunization Information System of the following (per CDC guidelines): Hepatitis B (Hep B), measles, mumps and rubella (MMR), tetanus, diphtheria, pertussis (Tdap), and varicella. Polio and influenza (seasonal flu) are recommended.	**YES**	**NO**
This student has documented proof of Tuberculosis (TB) screening (facility choice of skin test or IGRA blood test in accordance with CDC guidelines).	**YES**	**NO**
This student has documented proof of 10-panel drug screen, which must include screens for the following eight substances: Amphetamines, including methamphetamines; Barbiturates; Benzodiazepines; Cocaine; Marijuana; Methadone; Opiates; Phencyclidine.	**YES**	**NO**
This student has documented proof of Criminal Background Check: Must include social security number trace, state/national criminal background history, sex offender registry check, and OIG LEIE check.	**YES**	**NO**
This student has documented proof of CPR/Basic Life Support (BLS) for healthcare providers. It is recommended that trainings comply with the American Heart Association standard.	**YES**	**NO**
This student has documented proof of Bloodborne Pathogen training (OSHA).	**YES**	**NO**
This student has familiarity with OSHA-recommended safety guidelines (including fire and electrical safety; personal protective equipment; hazard communications; and infection prevention practices).	**YES**	**NO**
This student is covered by professional liability insurance coverage and general liability insurance coverage, or a combined policy that includes professional and general liability coverage, valid in the State of Oregon, for a minimum of $1 million per occurrence and$3 million per aggregate. The coverage must remain in place for the entire duration of each placement. Please attach proof.	**YES**	**NO**
This student has major medical insurance, valid in the State of Oregon, which will be in effect during the requested elective	**YES**	**NO**
This student is a U.S. citizen or has a valid visa to work in the United States.	**YES**	**NO**
Has this student ever required remediation or failed a course or clinical rotation?	**YES**	**NO**
This student is in good standing, and is qualified to take this clinical elective rotation, and is hereby authorized to take the requested clinical elective rotation at Legacy Health.	**YES**	**NO**

X _____ **Date:** _____
Signature of Institutional Representative (Program Director or Dean) *(mm/dd/yyyy)*

Home Inst. Coordinator Contact: _____
(admin staff for contact purposes) *(Please Print: first, last name)*

Email: _____ **Phone #:** _____
(000) 000-0000

Revised 04/2015