Spectrum Health

Application for rotation – Visiting Medical Student

SECTION I: To be completed by the Visiting Student

Last Name: First Name: Middle Initial:

Email Address:

Student Contact Phone:

Student Date of Birth: (Month/Day/Year)

Do you have a US Social Security number? Yes No

Language Fluency: Level of Proficiency:

Language Fluency: Level of Proficiency:

Language Fluency: Level of Proficiency:

Medical School: Expected Graduation Date: (Month/Year only)

School Contact: Phone:

School Contact Email Address:

Please select from the following and attach a personal statement describing why you are applying for a rotation with Spectrum Health / in West Michigan:

- I previously lived in West Michigan (Number of years:)
- I attended college (undergrad) in Michigan
- I have family in West Michigan
- I hope to complete my residency training and/or practice in West Michigan

Rotation Choices	Dates
	TO
	TO
	TO

Office of Research & Education Use Only

Approved_____ Date Coming_______________

Type of Learner International Med Student

Application Received____________________

Application Processed___________________

Spectrum Health

Visiting Medical Student Checklist

I understand visiting students are limited to one rotation, each specialty has different application requirements and that submission of an application does not constitute approval of rotation request or that I will be granted my top choice elective.

The Dean, Clinical Coordinator, or designee has completed and signed Section II of my application.
(OR)
I have attached (or requested from my school) a letter of good standing which verifies my academic status, approval to apply for this rotation, OSHA/Blood Borne Pathogen and HIPAA training, and professional liability insurance.

I understand if I am accepted for a rotation, I will be contacted and asked to complete a mandatory drug screen and background investigation.

I understand that if I am accepted, my rotation will be contingent on the establishment of an affiliation agreement between my school and Spectrum Health.

I have attached (or requested from my school) copies of all required documentation, including but not limited to:

- Certificate of Professional Liability Insurance which will provide coverage while rotating at Spectrum Health
  - Student must carry minimum $1 million occurrence and $3 million annual aggregate liability insurance *(Spectrum Health does not provide liability coverage for visiting students)*
- Current medical school transcript
- Curriculum Vitae (CV) or résumé
- Copy of USMLE Step 1 scores (if taken)
- Personal statement describing desire to complete a rotation with Spectrum Health

If accepted for a rotation, the student agrees to the following:

- Student will arrange his/her own housing and transportation
- Student will complete any required institutional and rotation-specific orientations
- Student will wear hospital issued ID badge(s) and adhere to rotation-specific dress code
- Student will comply with all specific training site policies
- Student will perform assigned duties to the best of his/her ability and work assigned shifts
- Student will maintain patient confidentiality by following all HIPAA regulations
- Student will provide preceptor with their school's evaluation form and instructions on returning it

Submit completed application **no less than 90 days in advance of rotation start date** via email to:

MedStudentScheduling@spectrumhealth.org.
Or mail to: Spectrum Health Office of Research & Education
Attn: Academic Scheduling
945 Ottawa Ave NW
Grand Rapids, MI 49503

Any rotation changes or cancellations should be communicated to the office of research & education as soon as possible and within 60 days of the rotation start. Students should not contact preceptors directly.

I authorize my medical school to release to Spectrum Health Office of Research & Education all performance and health information necessary to complete SECTION II of this application.

Applicant's Signature *Date*

Spectrum Health

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SECTION II - TO BE COMPLETED BY MEDICAL SCHOOL ADMINISTRATOR

Please provide the following information regarding

Printed Student's Name

YES NO The above named student is in good standing

YES NO The above named student has the required academic background and skills necessary to participate in and is approved to take the requested rotation.

If there have been any academic/clinical performance, liability, disciplinary, or other problems with this student, please explain:

YES NO The above-named student has completed training regarding HIPAA and hazardous materials, universal bodily fluid precautions, exposure to blood borne pathogens, and such other federal, state, and local laws and regulations relating to patient care in a hospital setting.

agrees to provide professional liability coverage

Name of School/University

for the above-named student during his/her rotation at Spectrum Health.

OR

Student will self-obtain required liability insurance coverage for duration of rotation at Spectrum Health.

A letter of good standing and certificates of completion of the required trainings may be attached in lieu of school representative completing the above section.

I agree to all of the preceding terms and affirm that all submitted information is correct:

Program Director / Dean / Academic Clinical Coordinator Signature *Date*

Printed Name