AdventHealth Medical Group

AdventHealth Orlando

MEDICAL STUDENT IPATIENT/OUTPATIENT APPLICATION PAGE 1/2

For **INPATIENT** AdventHealth Orlando hospital permissions with the ten hospitals of the Orlando facility, submit to: Heather.Hernandez@AdventHealth.com and Heather will ensure an academic affiliation agreement is on file with GME Administration, OPID has been granted for EMR and badge/door permissions have been requested with security.

Then for the **OUTPATIENT** EMR which is AdventHealth Medical Group Central Florida Division permissions, submit to: Caryl.Gunawardena@AdventHealth.com for Athena access once Heather verifies you have been fully credentialed as a medical student with AdventHealth. Heather cannot grant permissions outside of Orlando facilities listed on page two.

PROGRAM	☐ **NEW STUDENT/FIRST ROTATION**	☐ **RETURNING STUDENT**
Medical Student Third Year Core	Elective	Medical Student Fourth Year Elective

SURGICAL ROTATIONS Require Scrub Training at AdventHealth Orlando main campus and must be scheduled by Heather.

APPLICANT INFORMATION			
Last Name:	First Name:	Middle:	Date:
Gender ☐ M ☐ F DOB:	SSN or SIN:		Full SSN is required for computer access
School Issued Email Address:	Emergency Contact Name:		
Cell Phone:	Emergency Contact Phone:		
Are/were you employed by AdventHealth? Y N OPID:			
Expected Graduation Date:			

SCHOOL/PROGRAM CONTACT INFORMATION (OFFICIAL DESIGNATED TO RECEIVE CORESPONDENCE/AFFILIATION AGREEMENT/EVALUATION)			
School/Program Name:			
Contact Name:	Title:		
Street Address:	City:	State:	Zip
Business Phone:	Email:		

TRAINING STATEMENT
Are you aware of any limitations that would prevent you from performing the duties required for the training you are requesting? ☐ No ☐ Yes, Please Explain:

DISCLAIMER AND SIGNATURE	
I certify that my answers are true and complete to the best of my knowledge. If this application is approved, I understand that I am responsible for submitting all required documents, as indicated in this application, including any additional documents as requested by the AdventHealth. I agree to obtain prior written approval of AdventHealth before publishing any material related to the learning experience provided.	
Applicant Signature:	Date:
School Representative Signature:	Date:

MEDICAL STUDENT APPLICATION PAGE 2/2

Inpatient Outpatient Athena Department Name:

NAME OF ROTATION:

	Start Date:	End Date:

LOCATION: (select all that apply): ☐ AdventHealth Orlando ☐ AdventHealth for Women ☐ AdventHealth for Children
☐AdventHealth Altamonte ☐ AdventHealth Apopka ☐ AdventHealth Celebration ☐ AdventHealth East Orlando
☐AdventHealth Kissimmee ☐ AdventHealth Winter Garden ☐ AdventHealth Winter Park

Student Name:	Student School Name:

ADVENTHEALTH PRECEPTOR INFORMATION

I am a healthcare provider with an unrestricted license to practice in my specialty, and a current member of AdventHealth Medical Staff. By my signature below, I agree to precept the Student named above in a clinical rotation during the requested dates on this application. I assume full responsibility for the education, evaluation, conduct and actions of the student while on rotation.

Last Name:	First Name:	M.I.:	Credentials:

Employer: ☐ AdventHealth Orlando ☐ AdventHealth Medical Group (AHMG) ☐ Other:

Specialty:

Practice Name (if applicable):

Inpatient Unit/Department:

Practice Address:

Business Phone:	Email:

Supervising Physician/Preceptor Approval (REQUIRED)

Approved Start Date:	End Date:
Signature:	Date:

Inpatient Unit Director Approval ☐ *Not Applicable – No Inpatient Experience*

Name:	Title/Unit:
Signature:	Date:

Practice Manager/Leader Approval ☐ *Not Applicable – No Outpatient Experience*

Name:	Title/Unit:
Signature:	Date:

Heather Hernandez, AdventHealth Orlando | Graduate Medical Education Administration
Heather.Heranandez@AdventHealth.com

Caryl Gunawardena, AdventHealth Medical Group Central Florida Division | Human Resources
Caryl.Gunawardena@AdventHealth.com