AdventHealth Orlando

Graduate Medical Education

MEDICAL STUDENT CLINICAL ROTATION APPLICATION

APPLICANT INFORMATION	☐ FIRST AHO ROTATION/NEED ORIENTATION	☐ RETURNING ROTATION

Last Name:	First Name:	M.I.:	Date:

Gender ☐ M ☐ F	Date of Birth:	SSN:

School Issued Email Address:	Primary Phone:
Emergency Contact Name:	Emergency Contact Phone:
Have you been a student or employed at AdventHealth?	AdventHealth OPID:

SCHOOL/PROGRAM CONTACT INFORMATION (OFFICIAL DESIGNATED TO RECEIVE CORESPONDENCE/AFFILIATION AGREEMENT/EVALUATION)			
School/Program Name:			
Coordinator Name:	Title:		
Email:	Street Address:		
Business Phone:	City:	State:	Zip
Expected Graduation Date (m/d/y):	Business Fax:		

ROTATION REQUEST (One request per application.)	☐ Inpatient Experience	☐ Outpatient Experience
Preceptor Name (*First & Last*):	Credentials:	
Specialty/Department:	Rotation Start Date:	End Date:

RESEARCH: ☐ I understand research is not permitted unless part of my school's academic affiliation agreement during a clinical rotation.

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 Orlando GME Office. I agree to obtain prior written approval of AdventHealth before publishing any material related to the learning experience provided.

Applicant Signature	Date

CLINICAL INPATIENT HOSPITAL ROTATION APPLICATION		**PAGE 2**
Applicant Name:	Start Date:	End Date:
Program Name:		

PRECEPTOR STATEMENT (MUST BE COMPLETED TO PROCESS THIS APPLICATION)

I am a Physician with an unrestricted license to practice in my specialty, and current member of the AdventHealth Orlando Medical Staff. I have professional liability coverage in the amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000. By my signature below, I agree to precept the medical student in a clinical rotation. I agree to allow the medical student named above to complete the rotation dates requested on this application. I assume full responsibility for the education, evaluation, conduct and actions of the trainee while on rotation, credentialed to practice at AdventHealth Orlando System. I have a valid affiliation agreement with the designated academic institution. I am approved to precept students from this program. I agree to allow the student to complete the requested rotation(s). I assume full responsibility for the conduct and actions of the student while on rotation.

Last Name:	First Name:	M.I.	Credentials:
Street Address:	City:	State:	Zip:
Hospital Name:	Service/Dept.:		
Business Phone:	Business Fax:		
Mobile:	Email:		
Supervising Physician Preceptor Signature:		Date:	

REQUIRED DOCUMENTATION TO BE SUBMITTED TO NEW INNOVATIONS AFTER PRECEPTOR APPROVAL AND PRIOR TO ORIENTATION/START DATE - HEATHER WILL PROVIDE INSTRUCTIONS THE WEEK PRIOR TO ORIENTATION.

☐ Complete Clerkship Application with Preceptor Approval Signature (Preceptor Signature not required for VSAS or Podiatry) ☐ AdventHealth Orlando ESPAA Form – Computer Access Agreement Signed by Applicant	☐ PROOF OF MALPRACTICE LIABILITY INSURANCE*****
☐ LETTER OF GOOD STANDING from your School/Program – Please request from your clinical coordinator so you may upload directly to Ni	☐ LEVEL 1 BACKGROUND SECURITY CHECK*****
☐ 5-Panel Drug Screen (Amphetamines, Marijuana, Cocaine, Opiates, and Phencyclidine)* Negative and Valid if completed while enrolled in current program	☐ TUBERCULOSIS SCREENING (PPD, Quantiferon or Clear Chest X-ray) **Date:**
☐ COPY OF PHOTO ID, Student ID, Health Insurance* or Card	☐ RESPIRATORY MASK FIT CERTIFICATE **Date:**
☐ ALN CBL Transcript - After completing online training – Heather will send instructions – This will take about 90 minutes. ☐ AdventHealth Orientation Acknowledgement, Statement of Confidentiality, Badge Access Statement, Confidentiality Statement, Orientation Attestation ☐ COVID-19 Attestation Form COVID-19 Vaccine not required	☐ PROOF OF IMMUNIZATIONS* - MMR Vaccination - Varicella Vaccination or Immunity and Hepatitis B (If refused, you must provide a signed wavier) ☐ Flu shot required Dec-March (If refused must wear mask in all patient care areas.) **Date of Flu Shot:**

***THESE DOCUMENTS CAN BE COMPILED IN THE LETTER OF GOOD STANDING OR A LETTER OF ATTESTATION – if included in the letter, originals are not required.**

Submit Application via email to:
AdventHealth Orlando Graduate Medical Education
Heather M.S. Hernandez, Medical Student Clerkship Coordinator
Heather.Hernandez@AdventHealth.com