



MEDICAL STUDENT/RESIDENT APPLICATION

Today's Date _____

(Complete top of Page 1 and all of Page 2)

PLEASE PRINT:

Name in Full _____ Male _____ Female _____

Clerkship/Training Program in (Specialty area) _____

Responsible Physician(s) _____

From _____ To _____
(Month, Day & Year) (Month, Day & Year)

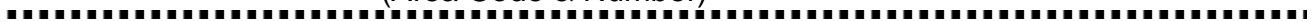
Level of Education: Medical School: 3rd yr 4th yr **(circle one)**
Residency: 1st yr 2nd yr 3rd yr 4th yr

Year & Month of Expected Graduation/Completion of Training Program _____

Name of Medical School/Training Program

Address _____

Training Program Director (Name) _____
Phone Number _____
(Area Code & Number)



VERIFICATION BY MEDICAL STAFF OFFICE

Date

- Copy of driver's license/State I.D. _____
- Immunization Record with PPD Test Date _____
- Received verification/clerkship approval from program _____
- Received verification of Liability Coverage _____
- Signed HIPAA/Confidentiality Forms _____
- Ingalls Hospital Student I.D. Badge _____

Responsible Sponsoring Physician Signature

Date

Permanent Address _____

Phone Number _____

Date of Birth _____

Place of Birth _____

Citizenship _____ If alien provide # _____

Status _____

What is the current status of your health? _____

Note: You must provide evidence of immunity to TB, Rubella, Rubeola and Varicella

Person to notify in an emergency:

Name _____

Relationship _____

Phone Number _____

Address _____

I understand that in all contacts with patients, family, friends of patients, and staff of Ingalls Memorial Hospital that I must wear a name badge identifying myself as a resident/student. Additionally, I understand that I must verbally identify myself as a resident/student and obtain oral permission to attend or be involved in the care of any patient with whom I may be assigned by my preceptor. I understand that I must be supervised at all times by a physician who is a member in good standing of Ingalls Memorial Hospital. I attest that all information furnished by me is true to the best of my knowledge and furnished in good faith. I understand that willful and significant omissions or misrepresentation may result in immediate termination of my affiliation. I agree to report any changes in my school status or health status that would affect my ability to complete my affiliation as outlined by Physician Sponsor or Preceptor.

Signature of Resident/ Student

Date