Ingalls

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