Rush-Copley Medical Center

Clinical Rotation/Observational Experience Request Form

Requested Dates: Start Date: _____ End Date: _____

Experience Requested: ☐ Clinical rotation ☐ Observational experience

Personal Information – PLEASE PRINT:

Name: _____
(First Name) (Middle Initial) (Last Name)

Address: _____

City: _____ State: _____ Zip: _____

Phone: ( )_____ Email: _____

Name of Sponsoring Physician: _____

Has Physician been notified? ☐ Yes ☐ No

Placement Requested: ☐ Family Medicine ☐ Internal Medicine ☐ Obstetrics / Gyn

☐ Surgery ☐ GI ☐ Anesthesia / Pain ☐ Radiology ☐ Pediatrics

Other: _____

Academic Institution: ☐ RUSH ☐ Midwestern University / CCOM ☐ Marianjoy Rehab

Other: _____

Student Coordinator Name: _____ Phone: ( ) _____

Current Course of Study: ☐ 3rd year Medical School ☐ 4th year Medical School

☐ Residency ☐ Fellowship ☐ Physician Assistant ☐ Nurse Practitioner

---

ADMINISTRATIVE REVIEW

Request for Clinical Privileges / Observation granted ☐ Yes ☐ No
Surgical Privileges granted; may scrub in any interventional area ☐ Yes ☐ No

_____ _____
Vice-President of Quality & Patient Safety Officer Date

_____ _____
Department Chair Date

_____

☐ I agree to provide direct supervision for the above-named student while at Rush-Copley Medical Center. I have received a copy the Rush-Copley "*Clinical Rotations*" policy and agree to abide by these guidelines. I understand this student: ☐ MAY scrub in ☐ MAY NOT scrub in

_____ _____
Signature of Supervising Physician Date