



FLORIDA HOSPITAL GRADUATE MEDICAL EDUCATION

2501 North Orange Avenue – Suite 235 – Orlando Florida 32804 Website: www.fhgme.com

Allied Health Application Please Type. Handwritten and / or Incomplete Applications will not be accepted.

APPLICANT STATUS			
<input type="checkbox"/> Allied Health Student	<input type="checkbox"/> Allied Health Professional	<input type="checkbox"/> Licensed Practitioner	<input type="checkbox"/> Other

APPLICANT INFORMATION			
Last Name		First	M.I. Date
Street Address			Apartment/Unit #
City		State	Zip
Phone		E-mail Address	
Date of Birth	Social Security Number		Gender <input type="checkbox"/> M <input type="checkbox"/> F
School or Program Name			Graduation Date
Home Phone		Mobile Phone	
Emergency Contact		Relationship	Phone

SPECIALTY		
<input type="checkbox"/> Advanced Registered Nurse Practitioner (ARNP)	<input type="checkbox"/> Physician Assistant (PA)	<input type="checkbox"/> Certified ST First Assistant (CST-FA)
<input type="checkbox"/> Certified Nurse Midwife (CNM)	<input type="checkbox"/> RN First Assistant (RNFA)	<input type="checkbox"/> Registered Radiology Assistant (RRA)
<input type="checkbox"/> Certified Registered Nurse Anesthetist (CRNA)	<input type="checkbox"/> Rounding Nurse	<input type="checkbox"/> Radiology Technologist (RT)
<input type="checkbox"/> Clinical Research Coordinator & Assistant	<input type="checkbox"/> Surgical Scrub (SC)	
<input type="checkbox"/> Pathologists' Assistant	<input type="checkbox"/> Advanced Surgical Technician (AST)	

AHP PRECEPTOR ASSIGNMENT		
AHP	Start Date	End Date
AHP	Start Date	End Date
AHP	Start Date	End Date

REQUIRED DOCUMENTATION (IF APPROVED ALL DOCUMENTAION MUST BE SUBMITTED TO THE GME OFFICE TWO WEEKS PRIOR TO SCHEDULED ARRIVAL)	
<input type="checkbox"/> LETTER OF GOOD STANDING	<input type="checkbox"/> PROOF OF PERSONAL HEALTH INSURANCE
<input type="checkbox"/> BACKGROUND SECURITY CHECK	<input type="checkbox"/> CERTIFICATE - RESPIRATORY MASK FIT SIZE
<input type="checkbox"/> PROOF OF MALPRACTCE LIABILITY INSURANCE	<input type="checkbox"/> PHYSICIAN/STUDENT COMPUTER ACCESS FORM – FH CAA
<input type="checkbox"/> PROOF OF IMMUNIZATIONS - PPD within 12 Months (annually) - MMR Vaccination - Varicella Vaccination or Immunity and Hepatitis B (If refused, you must provide a signed wavier)	

TRAINING STATEMENT
Are you aware of any limitations that would prevent you from performing the duties required for the training you are requesting?
<input type="checkbox"/> No <input type="checkbox"/> Yes Please explain:

PROGRAM INFORMATION OFFICIAL DESIGNATED TO RECEIVE CORRESPONDENCE/ EVALUATION			
School/ Program Name			
Last Name	First		Title
Street Address			Suite/Unit #
City	State	Zip	
E-mail Address			
Business Phone		Business Fax	

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.	
Signature	Date

APPROVAL DATES	
Start Date	End Date
Start Date	End Date
Start Date	End Date

AHP PRECEPTOR STATEMENT <input type="checkbox"/> Independent <input type="checkbox"/> Dependent			
As a member of the Medical Staff with appropriate privileges for procedures. I endorse the applicant to complete the approved rotations at Florida Hospital. This applicant will be under my full supervision. This applicant is in Good Standing and covered by Malpractice Liability Insurance. The applicant has a valid Florida Practitioners License.			
<input type="checkbox"/> No <input type="checkbox"/> Yes Please provide license Number _____			
AHP Last Name		First	M.I.
Physician Last Name		First	M.I. <input type="checkbox"/> MD <input type="checkbox"/> DO
Street Address		City	State Zip Suite/Unit #
Business Phone		Business Fax	Email
Signature, AHP Preceptor			Date
Signature, Supervising Physician			Date

DEPARTMENT OF GRADUATE MEDICAL EDUCATION (FOR GME USE ONLY)	
The applicant is:	<input type="checkbox"/> Approved <input type="checkbox"/> Declined
The applicant may:	<input type="checkbox"/> Assist Preceptor

Signature, GME Representative	Date
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Submit Documentation to: Florida Hospital Graduate Medical Education

Attention: GME Coordinator
 2501 North Orange Avenue, Suite 235
 Orlando, Florida 32804
 E-mail: FH.GME.Coordinator@flhosp.org
 Phone: 407.303.5270 Fax: 407.303.5273