FLORIDA HOSPITAL GRADUATE MEDICAL EDUCATION

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

CLERKSHIP APPLICATION

Handwritten and/or Incomplete Applications will not be accepted.

APPLICANT STATUS

☐ Medical Student	☐ Resident	☐ Fellow

APPLICANT INFORMATION

Last Name	First Name	M.I.	Date

Street Address	City	State	Zip	Apartment/Unit #

Gender ☐ M ☐ F	Date of Birth	Social Security No.

School/Program Name	Graduation Date

Home Phone	Mobile Phone

E-mail Address	Emergency Contact	Phone

FLORIDA HOSPITAL PRECEPTOR (IF APPLICABLE)

Last Name	First	M.I.	☐ MD ☐ DO ☐ DPM

TRAINING REQUEST

Specialty/Department	Start Date	End Date
Specialty/Department	Start Date	End Date

HOUSING REQUEST

Will you require housing? ☐ No ☐ Yes

If yes, **$50.00 Security Deposit** must be submitted at the time of approval to hold the reservation. No cash please.
We only accept a check or money order made payable to Florida Hospital GME **($200.00 per four week clerkship).** Rental fee is due at orientation.

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:

REQUIRED DOCUMENTATION OR LETTER OF ATTESTATION (MUST BE SUBMITTED TWO WEEKS PRIOR TO SCHEDULED START)

☐ LETTER OF GOOD STANDING	☐ PROOF OF MALPRACITCE LIABILITY INSURANCE
☐ CURRICULUM VITAE	☐ MEDICAL TRAINEE ACCESS FORM
☐ RESUME	☐ FH DATA MAINTENANCE FORM (RESIDENTS/FELLOWS)
☐ TUBERCULOSIS SCREENING (PPD) – ANNUAL REQUIREMENT	☐ RESPIRATORY MASK FIT CERTIFICATE –ANNUAL REQUIREMENT
☐ PROOF OF PERSONAL HEALTH INSURANCE	☐ OSHA QUESTIONNAIRE (IF TESTED AT FH - $25.00)
☐ BACKGROUND SECURITY CHECK	☐ HOUSING DEPOSIT (IF APPLICABLE - $50.00)
☐ PROOF OF IMMUNIZATIONS - MMR Vaccination - Varicella Vaccination or Immunity and Hepatitis B (If refused, you must provide a signed wavier)	☐ MEDICAL LICENSE (IF APPLICABLE)

PERSONAL STATEMENT

SCHOOL/PROGRAM CONTACT INFORMATION OFFICIAL DESIGNATED TO RECEIVE CORESPONDENCE/ EVALUATION

Last Name	First Name	☐ MD ☐ DO ☐ DPM
Title	Email	

Street Address	City	State	Zip	Suite/Unit #

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.

Applicant Name	
Applicant Signature	Date
Signature of Program Director (Residents /Fellows Only)	Date

APPROVAL TRAINING DATES (TO BE COMPLETED BY THE PRECEPTOR)

Service/Dept.	Start Date	End Date
Service/Dept.	Start Date	End Date

PRECEPTOR STATEMENT (MUST BE COMPLETED TO PROCESS THIS APPLICATION)

I am credentialed to practice at Florida Hospital. I have a valid affiliation agreement with the designated program. I am approved to precept students from this program. I agree to allow the students to complete the requested rotations. I assume full responsibility for the conduct and actions of the students while on rotation.

I understand that any false or misleading statement made on my application may be grounds for denial of this application. I hereby certify that the foregoing information is true and correct.

Last Name	First Name	M.I.	☐ MD ☐ DO ☐ DPM

Street Address	City	State	Zip	Suite/Unit #

Business Phone	Business Fax
Mobile	Email
Preceptor Signature	Date

DEPARTMENT OF GRADUATE MEDICAL EDUCATION (FOR GME USE ONLY)

The applicant is:	☐ Approved	☐ Declined
☐ Program Affiliation Agreement	☐ Required Documents on File	☐ GME Orientation Date

Signature, GME Representative	Date

Submit Documentation to: Florida Hospital Graduate Medical Education

Attention: GME Clerkship Coordinator
2501 North Orange Avenue, Suite 235 Orlando, Florida 32804
E-mail: FH.GME.CLERKSHIP@flhosp.org
Fax: 407.303.7323