

CLERKSHIP APPLICATION Handwritten and/or Incomplete Applications will not be accepted. Scanned PDF preferred.

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|--|-----------------------------------|-------------------------------------|---|
| APPLICANT STATUS | | <input type="checkbox"/> NEW | <input type="checkbox"/> RETURNING |
| <input type="checkbox"/> Medical Student | <input type="checkbox"/> Resident | Current PGY | <input type="checkbox"/> Fellow |

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|------------------------------|---|-------------------|--------------|---------------------|-----------|
| APPLICANT INFORMATION | | | | | |
| Last Name | | First Name | | M.I. | Date |
| Street Address | | Apt/Unit # | City | | State Zip |
| Gender | <input type="checkbox"/> M <input type="checkbox"/> F | Date of Birth | | Social Security No. | |
| School/Program Name | | | | Graduation Date | |
| Home Phone | | | Mobile Phone | | |
| E-mail Address | | Emergency Contact | | | Phone |

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|--|--|-------|------|--|
| FLORIDA HOSPITAL PRECEPTOR (NOTE: FLORIDA HOSPITAL IS UNABLE TO ASSIST IN FINDING PRECEPTORS) | | | | |
| Last Name | | First | M.I. | <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> DPM |

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|-------------------------|------------|----------|
| TRAINING REQUEST | | |
| Specialty/Department | Start Date | End Date |
| Specialty/Department | Start Date | End Date |

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| HOUSING REQUEST |
| Will you require housing? <input type="checkbox"/> No <input type="checkbox"/> Yes |
| If yes and upon confirmation of housing availability, a \$50.00 Security Deposit must be submitted immediately following 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. <u>All forms of payment must indicate name and date housing is requested.</u> |

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| 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: |

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| REQUIRED DOCUMENTATION (APPLICATIONS SUBMITTED WITHOUT THE REQUIRED DOCUMENTS WILL NOT BE CONSIDERED) | |
| <input type="checkbox"/> LETTER OF GOOD STANDING | <input type="checkbox"/> PROOF OF MALPRACTICE LIABILITY INSURANCE* |
| <input type="checkbox"/> BACKGROUND SECURITY CHECK* | <input type="checkbox"/> PROOF OF PERSONAL HEALTH INSURANCE* |
| <input type="checkbox"/> CURRICULUM VITAE | <input type="checkbox"/> TUBERCULOSIS SCREENING (PPD)** |
| <input type="checkbox"/> MEDICAL LICENSE (IF APPLICABLE) | <input type="checkbox"/> RESPIRATORY MASK FIT CERTIFICATE** (Required, however, students requiring mask fit testing can do so at FH) |
| <input type="checkbox"/> COPY OF PHOTO ID | <input type="checkbox"/> PROOF OF IMMUNIZATIONS - MMR Vaccination - Varicella Vaccination or Immunity and Hepatitis B (If refused, you must provide a signed wavier) |
| *THIS DOCUMENT CAN BE COMPILED IN THE LETTER OF GOOD STANDING OR A LETTER OF ATTESTATION | |
| **THIS DOCUMENTATION IS AN ANNUAL REQUIREMENT | |

PERSONAL STATEMENT

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SCHOOL/PROGRAM CONTACT INFORMATION (OFFICIAL DESIGNATED TO RECEIVE CORRESPONDENCE/ EVALUATION)

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|----------------|--|------------|------------|--------------------------|------|--------------------------|-------|--------------------------|-----|
| Last Name | | First Name | | <input type="checkbox"/> | MD | <input type="checkbox"/> | DO | <input type="checkbox"/> | DPM |
| Title | | | | Email | | | | | |
| Street Address | | | Apt/Unit # | | City | | State | | Zip |
| 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, as indicated in this application, including any additional documents as requested by the Florida Hospital GME Office.

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| 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 academic institution. I am approved to precept students from this program. I agree to allow the student to complete the requested rotation(s). I assume full responsibility for the conduct and actions of the student 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.

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|---------------------|--|------------|--------------|--------------|--------------------------|----|--------------------------|----|--------------------------|-----|
| Last Name | | First Name | | M.I. | <input type="checkbox"/> | MD | <input type="checkbox"/> | DO | <input type="checkbox"/> | DPM |
| Street Address | | | Suite/Unit # | | City | | State | | Zip | |
| Business Phone | | | | Business Fax | | | | | | |
| Mobile | | | | Email | | | | | | |
| Preceptor Signature | | | | | | | | | Date | |

EXTERN APPLICATION STATUS (FOR GME ADMINISTRATIVE USE ONLY)

| | | |
|--|---|---|
| The applicant is: | <input type="checkbox"/> Approved | <input type="checkbox"/> Declined |
| <input type="checkbox"/> Program Affiliation Agreement | <input type="checkbox"/> Required Documents on File | <input type="checkbox"/> GME Orientation Date |

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|-------------------------------|------|
| 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