FLORIDA HOSPITAL
Graduate Medical Education

The skill to heal. The spirit to care.®

For FHGME Administration Use Only:	
Approved by: _____	*Orientation Date:*_____
Required Documents on File	___
Requires Mask Fit	___
Requires Scrub Training	___
Updated Mask Fit	___
Updated PPD	___

MEDICAL STUDENT CLERKSHIP APPLICATION

ROTATION TYPE	☐ **FIRST ROTATION AT FH**	☐ **RETURNING STUDENT**
☐ Third Year Elective Medical Student (MS3)	☐ MS3 Core (year-long rotation)	
☐ Fourth Year Elective Medical Student (MS4)	☐ International Medical Student	

APPLICANT INFORMATION				
Last Name:		First Name:	M.I.:	Date:
Gender	☐ M ☐ F	Date of Birth:	SS#	
School Issued Email Address:			Primary Phone:	
Emergency Contact Name:			Emergency Contact Phone:	

SCHOOL/PROGRAM CONTACT INFORMATION (OFFICIAL DESIGNATED TO RECEIVE CORESPONDENCE/AFFILIATION AGREEMENT/EVALUATION)			
School/Program Name:	Expected Graduation Date (mm/yy):		
Coordinator First Name:	Coordinator Last Name:		
Title:	Email:		
Street Address:	City:	State:	Zip
Business Phone:	Business Fax:		
ROTATION REQUEST (One request per application)	☐ Inpatient Experience	☐ Outpatient Experience	
Preceptor Name (*First & Last*):	Credentials:		
Specialty/Department:	Rotation Start Date:	End Date:	

RESEARCH (Research is considered extracurricular activity. Participants are considered volunteers will be directed to FH Volunteer services for additional processing)

☐ I <u>do</u> intend to participate in research while on rotation	☐ I <u>do not</u> intend to participate in research while on rotation

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:

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. I agree to obtain prior written approval of Florida Hospital before publishing any material related to the learning experience provided.

Applicant Signature	Date

APPLICANT NAME:	REQUIRED DOCUMENTATION CHECKLIST
☐ Complete Application with Preceptor Approval Signature	☐ Proof of Malpractice Liability Insurance*
☐ FHESPAA (New applicants only)	☐ Background Security Check* Clear and Valid if completed while enrolled in program
☐ Letter of Good Standing from your School/Program	☐ Medical License (if applicable)
☐ Curriculum Vitae (if Visiting Resident/ Fellow)	☐ Respiratory Mask Fit Certificate*, ** (within 12 months)
☐ Copy of Photo ID/ Student ID	☐ Tuberculosis Screening (PPD)*, ** (within 12 months)
☐ Proof of Personal Health Insurance* or copy of card	☐ 5- Panel Drug Screen (Amphetamines, Marijuana, Cocaine, Opiates, and Phencyclidine) * Negative and Valid if completed while enrolled in program
☐ PROOF OF IMMUNIZATIONS* - MMR Vaccination- Varicella Vaccination or Immunity and Hepatitis B (If refused, you must provide a signed wavier). Flu shot required if rotating in the months of December- March (If refused must wear mask in all patient care areas).	

REQUIRED DOCUMENTATION MUST BE SUBMITTED AT LEAST TWO WEEKS PRIOR TO APPROVED START DATE

***THIS DOCUMENT CAN BE COMPILED IN THE LETTER OF GOOD STANDING OR A LETTER OF ATTESTATION**
****THIS DOCUMENTATION IS AN ANNUAL REQUIREMENT**

FLORIDA HOSPITAL PRECEPTOR INFORMATION

I am a Physician with an unrestricted license to practice in my specialty, and current member of the Florida Hospital Medical Staff. I have professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000. By my signature below, I agree to precept the Student or Resident in a clinical rotation. I agree to allow the Student named above to complete the rotation dates requested on this application. I assume full responsibility for the education, evaluation, conduct and actions of the students while on rotation.

Last Name:	First Name:	M.I.:	Credentials:

Employer: ☐ Florida Hospital (GME) ☐ Florida Hospital Medical Group (FHMG) ☐ Other:

Street Address:	Unit #	City:	State:	Zip

Business Phone:	Business Fax:	Email:

Preceptor Approval

Approved Start Date:	End Date:
Signature, Supervising Physician:	Date:

Submit All Documentation to:
Heather Hernandez, GME Clerkship Coordinator
2501 North Orange Avenue, Suite 235, Mailbox 38
Orlando, FL 32804
Email: FH.GME.CLERKSHIP@flhosp.org
Office: 407-303-7327
Fax: 407-303-7323