Ob/Gyn Graduate Medical Education
1960 Ogden St. Suite 360 Denver CO 80218
Office: 303-318-3270 Fax: 303-318-3274

MEDICAL STUDENT CLINICAL ROTATION APPLICATION

A. Student Information

Full Name:		
Elective:	___ Gynecology	___Urogynecology
Rotation Dates:	1st Choice: _____ to _____	2nd Choice: _____ to _____
Social Security: (Last 4 digits only)		
Date of Birth:		
Cell #:		
Address:		

B. SJH Rotation Information

SJH Dept:	**Ob/Gyn Residency Program**
SJH Preceptor/Supervisor:	**Christine Giesing, MD/ Jennifer Libra Program Administrator**
Contact Phone & E-mail:	**303-318-3270/jennifer.libra@sclhealth.org**

C. Current School/Program Information

Program Name	
Program Address	
Phone:	
Fax:	
Student Coordinator:	
Coordinator's Phone and Email:	

D. Student Attestation

I understand that I can not begin my student rotation until all information on this application has been received and verified by the Graduate Medical Education Office.

I understand that in all contacts with patients, family, friends or patients, and staff of Saint Joseph Hospital that I must wear a badge identifying myself as a student.

I understand that in order to obtain a Saint Joseph Hospital ID I must present a current Photo ID (driver's license, visa) to the Graduate Medical Education Office for verification.

Additionally, I must verbally identify myself as a student and obtain oral permission to attend or be involved in the care of any patient with whom I may be assigned.

I understand that I must be supervised at all times by a physician (MD/DO/DPM) who is a member in good standing at Saint Joseph Hospital.

I attest that all information provided by me is true to the best of my knowledge and is provided in good faith. I understand that willful and significant omissions or misrepresentation may result in immediate termination of my affiliation.

I agree to report any changes in my school status or health status that would affect my ability to complete my affiliation as outlined by my supervisor.

	NO	YES
1. Have you ever voluntarily or involuntarily been suspended, restricted, or terminated from any affiliation or relationship with any school or education facility?		
2. Have you ever received a formal reprimand or disciplinary action or been the subject of disciplinary proceedings or investigations at any school, hospital, or health care facility?		
2a: If Yes , are any such proceedings in progress?*		
3. Do you have or you every had a physical or mental condition (including drug or alcohol abuse) that could affect your ability to exercise the activities associated with this rotation or would require accommodation in order for you to perform activities requested in a safe and competent manner?		
4. Do you currently suffer from any communicable disease that could be transmittable?		

Students Signature:	
Date:	

MANDATORY DOCUMENTATION CHECKLIST FOR SCHOOL AND/OR STUDENT

APPLICATION FOR CLINICAL CLERKSHIP

In addition to the completed application, we also require the following:

	Letter of good standing from your Dean's office, this should include assurance of: a. Health insurance coverage b. Professional liability insurance coverage amounts c. Universal Precautions Training as defined by the CDC d. OSHA Training (including blood-borne pathogens) e. HIPAA Training from student's institution/program
	Copy of current school transcript
	Current curriculum vitae
	Personal Statement (typed please)
	A recent 2x2 photograph
	USMLE Step 1 transcript (must be 220 or higher, first time try)
	Proof if immunization as follows (hospital requirement): A. MEASLES (rubeola) 1. Persons born before 1957 are considered naturally immune to measles. 2. Persons born in or after 1957 must present evidence of two (2) live vaccine immunizations since 1968, or laboratory documentation (positive rubeola antibody polyvalent screen) to be considered immune. 3. Those persons without such documentation must be immunized. B. RUBELLA 1. Only persons who offer proof of immunity (i.e., documented positive rubella titer of proof of prior immunization) are considered immune to rubella. 2. Those persons without such written documentation are required to have a rubella titer through a blood test, then immunized as appropriate. C. CHICKENPOX (varicella 1. Should a person have a negative or questionable history of chickenpox, he/she will not be allowed to provide care to patients with chickenpox or herpes zoster. 2. Any exposure to chickenpox or herpes should be reported to the school and/or to the assigned hospital department. The person will not be able to come to work from day ten (10) through day twenty-one (21) after exposure. D. TB SKIN TESTING 1. Verification on record with the sponsoring agency of TB skin testing per CDC guidelines. E. TB MASK FIT TESTING 1. Verification on record of TB fit testing per CDC guidelines as performed by the sponsoring agency. This is especially for those non-employees who cannot avoid contact with actual or suspected TB patients. F. FLU VACCINACTION 1. Verification on record of flu vaccination if rotation is between October and March.