

## Application for rotation – Visiting Medical Student

### SECTION I: To be completed by the Visiting Student

Legal Last Name:

Legal First Name:

Middle Initial:

School or Professional Email Address:

Student Contact Phone:

Student Date of Birth:

(Month/Day/Year)

Do you have a US Social Security number?

Yes

No

Student Social Security Number:

If you have a US SSN it is required for system access; if not a temporary number will be assigned

Language Fluency:

Level of Proficiency:

Language Fluency:

Level of Proficiency:

Primary language of medical school instruction:

Alternate/additional language(s) of medical school instruction:

Medical School:

Expected Graduation Date

(Month/Year only)

School Contact (for confirmation of student records, affiliation agreements, etc.):

School Contact Email Address:

Please select from the following and attach a personal statement describing why you are applying for a rotation with Corewell Health in West Michigan:

I previously lived in West Michigan  
(Number of years: )

I attended college (undergrad) in Michigan

I have family in West Michigan

I hope to complete my residency training and/or practice in West Michigan

Please list the residency / specialty you intend to apply to:

**Rotation Choices**

**Dates**

TO

TO

TO

## Visiting Medical Student Checklist

I understand that Corewell Health in West Michigan only accepts applications from students attending international medical schools with which we have an existing affiliation agreement. If my school does not, I am not eligible to apply.

I understand visiting students are limited to one rotation in the fourth or final year of medical school only, and graduates are not eligible to apply as visiting medical students.

I understand each specialty has different application requirements and that submission of an application does not constitute approval of rotation request or that I will be granted my top choice elective.

The Dean, Clinical Coordinator, or designee has completed and signed Section II of my application.

(OR)

I have attached (or requested from my school) a letter of good standing which verifies my academic status, approval to apply for this rotation, OSHA/Blood Borne Pathogen and HIPAA training, and professional liability insurance.

I understand if I am accepted for a rotation, I will be contacted and asked to complete a mandatory drug screen and background investigation.

I have attached (or requested from my school) copies of all required documentation listed below. Applications must be complete to move forward in the review process.

Current medical school transcript

Curriculum Vitae (CV) or résumé

Copy of USMLE Step 1 score report (if taken)

Personal statement describing desire to complete a rotation with Corewell Health in West Michigan

Certificate of Professional Liability Insurance which will provide coverage while rotating at Corewell Health in West Michigan (may be submitted after a rotation is offered and accepted)

*\*Student must carry minimum \$1 million occurrence and \$3 million annual aggregate liability insurance (Corewell Health does not provide liability coverage for visiting students)*

If accepted for a rotation, the student agrees to the following:

- Student will arrange their own housing and transportation
- Student will complete any required institutional and rotation-specific orientations
- Student will provide their full social security number to Corewell Health in West Michigan as required through onboarding in order to obtain physical (badge) and logical (computer/EMR) access
  - \*Students who do not have a US SSN will be assigned a proxy SSN*
- Student will wear hospital issued ID badge(s) and adhere to rotation-specific dress code
- Student will comply with all specific training site policies
- Student will perform assigned duties to the best of his/her ability and work assigned shifts
- Student will maintain patient confidentiality by following all HIPAA regulations
- Student will provide preceptor with their school's evaluation form and instructions to submit it

Once accepted for a rotation, the student (or school) will pay the \$100 non-refundable application fee online at [www.onlineregistrationcenter.com/MedStudent26-27](http://www.onlineregistrationcenter.com/MedStudent26-27). Application fee must be paid prior to starting a clinical rotation.

Submit completed application **no less than 70 days (10 weeks) in advance of rotation start date** via email to:

[CHWMedStudentScheduling@corewellhealth.org](mailto:CHWMedStudentScheduling@corewellhealth.org)

Any rotation changes or cancellations should be communicated to the office of medical education as soon as possible and within 60 days of the rotation start. Students should not contact preceptors directly.

**I authorize my medical school to release to the Office of Medical Education all performance and health information necessary to complete SECTION II of this application.**

*Applicant's Signature*

*Date*

## Application for rotation – Visiting Medical Student

### SECTION II - TO BE COMPLETED BY MEDICAL SCHOOL ADMINISTRATOR

Please provide the following information regarding

*Printed Student's Name*

YES	NO	The above named student is in good standing
YES	NO	The above named student has the required academic background and skills necessary to participate in and is approved to take the requested rotation.

If there have been any academic/clinical performance, liability, disciplinary, or other problems with this student, please explain:

YES	NO	The above-named student has completed training regarding HIPAA and hazardous materials, universal bodily fluid precautions, exposure to blood borne pathogens, and such other federal, state, and local laws and regulations relating to patient care in a hospital setting.
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agrees to provide professional liability coverage

*Name of School/University*

for the above-named student during his/her rotation at Corewell Health in West Michigan.

**OR**

Student will self-obtain required liability insurance coverage for duration of rotation at Corewell Health in West Michigan.

***A letter of good standing and certificates of completion of the required trainings may be attached in lieu of school representative completing the above section.***

I agree to all of the preceding terms and affirm that all submitted information is correct:

*Program Director / Dean / Academic Clinical Coordinator Signature*

*Date*

*Printed Name*