Spectrum Health

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 Spectrum Health System Access; if not a temporary number will be assigned

Language Fluency: English Level of Proficiency: ---Please Select---

Language Fluency: _____ Level of Proficiency: ---Please Select---

Language Fluency: _____ Level of Proficiency: ---Please Select---

Medical School: _____ Expected Graduation Date: _____ (Month/Year only)

School Contact: _____ Phone: _____

School Contact Email Address: _____

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

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

☐ I have family in West Michigan

☐ I attended college (undergrad) in 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	_____	

Office of Research & Education Use Only

Approved_____ Date Coming_____

Type of Learner International Med Student

Application Received_____

Visiting Medical Student Checklist

☐ I understand visiting students are limited to one rotation, 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 understand that if I am accepted, my rotation will be contingent on the establishment of an affiliation agreement between my school and Spectrum Health.

☐ I have attached (or requested from my school) copies of all required documentation, including but not limited to:
- Certificate of Professional Liability Insurance which will provide coverage while rotating at Spectrum Health
  - Student must carry minimum $1 million occurrence and $3 million annual aggregate liability insurance *(Spectrum Health does not provide liability coverage for visiting students)*
- Current medical school transcript
- Curriculum Vitae (CV) or résumé
- Copy of USMLE Step 1 scores (if taken)
- Personal statement describing desire to complete a rotation with Spectrum Health

☐ If accepted for a rotation, the student agrees to the following:
- Student will arrange his/her own housing and transportation
- Student will complete any required institutional and rotation-specific orientations
- Student will provide their full social security number to Spectrum Health as required through onboarding in order to obtain physical (badge) and logical (computer/EMR) access
  - Students who do not have a US SSN should contact Spectrum Health so a proxy SSN may be assigned
- 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 on returning it

Submit completed application **no less than 90 days in advance of rotation start date** via email to:

MedStudentScheduling@spectrumhealth.org

Any rotation changes or cancellations should be communicated to the office of research & 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 Spectrum Health Office of Research & 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.

_____ agrees to provide professional liability coverage
Name of School/University

for the above-named student during his/her rotation at Spectrum Health.

OR

☐ Student will self-obtain required liability insurance coverage for duration of rotation at Spectrum Health.

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