WELLSPAN
Good Samaritan Hospital

APPLICATION FOR MEDICAL STUDENT ROTATION

SECTION I: PERSONAL INFORMATION (To be completed by student)

Last Name First Name Middle

Date of Birth Social Security No. (last 4 digits) XXX-XX-_____

Student Mailing Address

Student E-mail Student Preferred Phone#

Name of Emergency Contact Emergency Contact Relationship

Emergency Contact Phone#

Emergency Contact Email

Current Medical School

Name of Contact Person in Registrar's Office

Email of Contact Person in Registrar's Office

Registrar's Office Address

Expected Degree Graduation Date

Registrar's Phone Registrar's Fax

I understand that the application materials submitted become the property of The Good Samaritan Hospital of Lebanon, Pennsylvania. I attest that the information given in this application to be true and accurate.

Student's Signature: _____ Date: _____

SECTION II: ELECTIVES REQUESTED (To be completed by student)
Please list in order of priority. It is helpful if you list a few requests in case your top choice of date is unavailable.

Dates

1.

2.

3.

Application for Elective Study/ Visiting Students

SECTION III: DEAN OR REGISTRAR VERIFICATION

(To be completed by authorized official of student's school)

Student Last Name Student First Name

Current Medical School (Home Institution)

☐ This student will enter his/her fourth year on _____/_____/_____ month/day/ year

☐ Student's expected graduation date _____/_____/_____ month/day/ year Degree:

☐ This student is in good academic standing at home institution Yes No

☐ This student will pay tuition at home institution during the period indicated Yes No

☐ Personal Health Insurance Coverage is in effect while the student is away from home institution Yes No
(a copy of current insurance card must be attached)

☐ Malpractice insurance is in effect while away from home institution Yes No
(proof of malpractice insurance must be attached)

☐ This student has met all immunization requirements defined by home institution Yes No
MUST include Proof of Influenza Vaccination for students completing a rotation between October 1 – March 31
(a copy of immunization record must be attached)

☐ This student has completed HIPAA training (required) Yes
No

☐ This student has completed OSHA training (required) Yes No

☐ This student has completed criminal background check (required) Yes No

☐ This student has completed **Pennsylvania** child abuse clearance check (required) Yes No

☐ This student will receive credit for this elective Yes
No

☐ At the end of the elective, an evaluation will be required Yes No
Please include any evaluation in this application packet

Please submit all materials to:	***A raised school seal must be affixed to this document.**
Mrs. Sally A Bachman Family Medicine/ Medical Student Program Coordinator P.O. Box 1520 Lebanon, PA 17042 sbachman3@wellspan.org (717) 270-1949 Fax (717) 270-1958	**School Seal**

School Official's Name: _____

School Official's Title: _____

School Official'sSignature: _____

Date: _____

By signing this Application, the undersigned agrees to be bound by all Hospital policies and procedures, including, but not limited to, policies dealing with patient confidentiality.

SIGNATURE OF APPLICANT_____ **DATE** _____