East Alabama Health

Medical Student Rotation Application

Date Application Completed: _____

Personal data:

Full Name: _____

Permanent Address: _____

City, State, Zip: _____

Gender: Male _____ Female _____ U.S. Citizen: Yes _____ No _____

Email Address: _____

AAMC ID# _____

Address while on rotation:

Visiting Address: _____

City, State, Zip: _____

Emergency Contact & Relationship: _____

Telephone: _____

Medical School: _____

Rotation Dates Requested: _____

Required Student Documentation:

- Current Letter of Good Standing from Medical School
- Copy of Picture ID
- Proof of Malpractice Coverage/Professional Liability Insurance
- Copy of rotation evaluation form from school
- Copy of USMLE Step-1 scores or COMLEX Level-1 scores
- Proof of Medical Insurance
- Immunization Record to include PPD (tuberculosis) status, MMR and flu shot

Personal Statement:

Please provide a brief narrative explaining why you are interested in completing a rotation with East Alabama Health (EAMC) Psychaitry Residency Program. Please include your specialty considerations and academic and career goals.

_____

_____

_____

Are you aware of any limitation(s) that would prevent you from performing the duties of the rotation for which you are applying? No _____ Yes _____ If yes, please explain:

_____

_____

Hold Harmless Statement:

I, the undersigned, do knowingly and voluntarily hereby, waive, release, and hold harmless East Alabama Health, its employees, faculty and residents from any liability or claim, demand action, judgement, court cost, reasonable attorney fees and liability of any kind for damages as a result of any injury sustained by me during performance of a rotation at East Alabama Health. I accept full responsibility and agree to exercise reasonable precautions in the interest of safeguarding my health and well-being while participating in the rotation.

_____ _____

Student Signature Date

Confidentiality Acknowledgement

I, the undersigned do hereby acknowledge that East Alabama Health has provided me access to patients' medical records and other patient care information. In consideration of this provision, I agree that:

1. I will not disseminate, discuss or relate the contents of any of these records except as necessary during care of the patient.
2. I will not disseminate, discuss or relate any communications concerning a patient. I understand that these communications include but are not limited to diagnosis, medical treatment, nursing care and billing information. I will not allow anyone else to access patient information using my name or password. Further, I understand that any access made using my name or password will be attributed to me.
3. Any breach of patient confidentiality related to my accessing any medical records or patient information could result in my access to this information being denied.
4. Any violation of this or any other policy relating to this confidentiality of patient information can result in disciplinary, punitive, and/or legal action being taken against me. Further, I agree to indemnify and hold East Alabama Health and/or its affiliated facilities harmless for any liability arising from my violation of this policy.

_____ _____

Name Date

_____

Signature

I certify that the information provided on this application is true, accurate and complete.

_____ _____

Signature