AdventHealth Orlando

Submit Documentation to:
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CLERKSHIP/ VISITING RESIDENT APPLICATION

SPECIALTY	**NEW** ☐ **RETURNING** ☐
☐ Medical Student Third Year Applicant ☐ Yearlong Core	☐ Medical Student International Applicant
☐ Medical Student Fourth Year Applicant	☐ Visiting Resident/Fellow

APPLICANT INFORMATION				
Last Name	First Name		M.I.	Date
Gender ☐ M ☐ F	Date of Birth	Medical License Number (if applicable)		SS#
National Provider Number (if applicable)		E-mail Address		
Home Phone		Mobile Phone		
Emergency Contact Name		Emergency Contact Phone		

SCHOOL/PROGRAM CONTACT INFORMATION (OFFICIAL DESIGNATED TO RECEIVE CORESPONDENCE/ EVALUATION)			
School/Program Name	Expected Graduation Date mm/yy		
Coordinator First Name	Coordinator Last Name		
Title	Email		
Street Address	City	State	Zip
Business Phone	Business Fax		

AdventHealth Orlando Preceptor (Note: AdventhHealth is unable to assist in finding Preceptors)
TRAINING REQUEST (One request per application)

Last Name	First Name	MI	☐ MD ☐ DO ☐ DPM ☐ PhD
Specialty/ Department		Start Date	End Date

TRAINING STATEMENT

Are you aware of any limitations that would prevent you from performing the duties required for the training you are requesting?
☐ No ☐ Yes, Please Explain:

DISCLAIMER AND SIGNATURE

I certify that my answers are true and complete to the best of my knowledge. If this application is approved, I understand that I am responsible for submitting all required documents, as indicated in this application, including any additional documents as requested by the AdventHealth Orlando GME Office. I agree to obtain prior written approval of AdventHealth Orlando before publishing any material related to the learning experience provided.

Applicant Signature	Date

REQUIRED DOCUMENTATION	TO BE SUBMITTED TWO WEEKS PRIOR TO START DATE AFTER APPROVAL
☐ Complete Application with Preceptor Approval Signature	☐ Proof of Malpractice Liability Insurance*
☐ FHESPAA (New applicants only)	☐ Background Security Check* Clear and Valid if completed while enrolled in program
☐ Letter of Good Standing from your School/Program	☐ Medical License (if applicable)
☐ Curriculum Vitae (if Visiting Resident/ Fellow)	☐ Respiratory Mask Fit Certificate*, ** (within 12 months)
☐ Copy of Photo ID/ Student ID	☐ Tuberculosis Screening (PPD)*, ** (within 12 months)
☐ Proof of Personal Health Insurance* or copy of card	☐ 5- Panel Drug Screen (Amphetamines, Marijuana, Cocaine, Opiates, and Phencyclidine)* Negative and Valid if completed while enrolled in program
☐ PROOF OF IMMUNIZATIONS* - MMR Vaccination- Varicella Vaccination or Immunity and Hepatitis B (If refused, you must provide a signed wavier). Flu shot required if rotating in the months of December- March (If refused must wear mask in all patient care areas).	
***THIS DOCUMENT CAN BE COMPILED IN THE LETTER OF GOOD STANDING OR A LETTER OF ATTESTATION ****THIS DOCUMENTATION IS AN ANNUAL REQUIREMENT**	

AdventHealth Orlando PRECEPTOR INFORMATION					
I am a Licensed Physician with an unrestricted license to practice in my specialty. I have professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000. By my signature below, I agree to precept the Student or Resident in a clinical rotation. I agree to allow the Student or Resident to complete the rotation dates requested on this application. I assume full responsibility for the education, evaluation, conduct and actions of the students while on rotation.					
Physician Last Name	First Name		M.I.	☐ MD ☐ DO ☐ DPM ☐ PhD	
Street Address	Unit #	City	State	Zip	
Business Phone	Business Fax	Email			
DATES APPROVED					
Start Date	End Date				
Signature, Supervising Physician	Date				
CLERKSHIP APPLICATION STATUS (FOR GME ADMINISTRATION USE ONLY)					
The Applicant is:	☐ Approved	☐ Declined			
☐ Required Documents on File	☐ GME Orientation Date				