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

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

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 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	

Visiting Medical Student Checklist

☐ I understand visiting students are limited to one rotation in the fourth or final year of medical school only, and medical school 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 understand that if I am accepted, my rotation will be contingent on the establishment of an affiliation agreement between my school and Corewell Health in West Michigan.

☐ 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 on returning it

☐ Once accepted for a rotation, the student (or school) will pay the $100 non-refundable application fee online at www.onlineregistrationcenter.com/MedStudent24-25. Application fee must be paid prior to starting a clinical rotation.

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

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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 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