Samaritan Health Services

Application for Medical Student Clinical Rotation

APPLICANT INFORMATION

Name: (Last)_____ (First)_____ (MI)____ Telephone:_____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Email:_____ Medical School:_____ Graduation Date:_____

Emergency Contact:_____ Telephone:_____

To student: You are responsible for the accuracy of all information and documentation submitted as part of this application.

Clinical Rotation/ Location Requested	Requested Dates 1st Choice		Requested Dates 2nd Choice	
	Start Date	End Date	Start Date	End Date
1.				
2.				

INSTITUTIONAL INFORMATION

Please check the appropriate box to indicate that the standard has been met and documentation exists. Samaritan reserves the right to request copies of supporting documentation at any time.

		Check appropriate box below. YES	NO
1.	A Clinical Affiliation Agreement between the student's institution and Samaritan Health Services (SHS) has been established.	○	○
2.	Proof of current Professional Liability & General Liability insurance.	○	○
3.	Letter of reference (good standing)/request for student rotation from the school.	○	○
4.	Specifics of Clinical Rotation (Course requirements, skills, hours, etc.)	○	○
5.	School/Program contact information (name of program, contact person, email and phone number).	○	○
6.	Student contact information (name, phone number and email address).	○	○
7.	Student Emergency Contact Information (Name, phone number).	○	○
8.	Current Criminal Background Check (performed by approved vendor according to OHA rules, completed within the past 12-24 months of the start of student's rotation.	○	○
9.	Current Urine Drug Screen (10-panel drug test by reputable vendor according to OHA rules, result must have been done within the past 12 months preceding the start of student's rotation. If student needs a UDS, then he/she may arrange to do one through the SHS Occupational Medicine Department. Student will be responsible for the cost.	○	○
10.	Current Student Immunization records to include: ◆ Hep B Series or +Hep B titer results ◆ MMR Series **or** Immune Titers ◆ Tdap (from last 10 years) ◆ Varicella Series or +Titer ◆ (Negative) 2-step TST or IGRA within past year ◆ Influenza Vaccination/Declination ◆ COVID-19 Vaccination Series/Declination	○	○
11.	Current AHA BLS training	○	○
12.	Documentation from School/Program that the student has received prior training (compliant with federal OSHA requirements) on: Bloodborne Pathogen training, Fire & Electrical Safety, PPE, Hazard Communications & Infection Prevention Practices.	○	○
13.	SHS Online Orientation Modules and Health Testing Guidelines **(Must be done after approval of rotation but prior to starting rotation)**		

The above named student is qualified to request this clinical rotation and is hereby authorized to accept the requested clinical rotation with Samaritan Health Services. Institution agrees to supply any supporting documentation upon request.

Please print name (Institutional Representative) _____ Title _____ Email Address _____

Signature of Institutional Representative (Clerkship Director or Coordinator) _____ Date _____

Institution Name:_____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Please return via email to medicaleducation@samhealth.org or via mail to the following address:
Good Samaritan Regional Medical Center, Office of Medical Education, 3600 NW Samaritan Drive, Corvallis, OR 97330. Tel: 541-768-4906