Madisonhealth

Application and Agreement for Students (PA's, NP's, CNM's & Medical Students) Following Physicians in Clinical Rotations

A

Name _____

DOB: _____

Address _____

City, State, ZIP _____

Phone number day _____ evening _____

Email _____

School _____ Grade level _____

Clinical Rotation _____

☐ I have already made specific arrangements with a MMH credentialed physician to do clinical rotation with him/her.

Physician Name: _____ Phone #:_____

Dept. /Unit: Dates/times approved:

B

I understand that all information about patients, whether it is medical or personal, is absolutely confidential, and I will not discuss or repeat anything that I see, read or hear. I have read and signed the Madison Memorial Hospital Confidentiality Statement.

I agree to the following statements:

- I have supplied a copy of my immunization record.
- I have supplied a copy of my liability insurance.
- I have not had any exposure to measles, mumps, rubella (German or 3-day measles) or chickenpox in the last 30 days. I understand that I will **not participate** in any activities within the hospital if I am experiencing signs or symptoms of an acute communicable illness. Those signs and symptoms include fever, rash and cough especially if combined with fatigue, aches or any previously mentioned symptoms (flu-like symptoms). I also do not have any symptoms of active tuberculosis such as cough with sputum or blood, lasting 2 or more weeks, fever, unexplained weight loss, or awakening from sleep with excessive sweating.
- I will be with a physician supervisor at all times when with patients.

I agree to hold harmless Madison Memorial Hospital from any present and future liability and/or damages for injuries arising from or growing out my clinical rotation.

Signature: _____ Date: _____

C

TO BE COMPLETED AT TIME OF CLINICAL ROTATION

I understand that I will be responsible for this person for the duration of this Clinical Rotation.

Name of Supervising Physician: _____ ***Signature***_____

Work phone number: _____ ***Date***: _____

Signature of MD Supervisor: _____ ***Date:*** _____

Signature of applicant/student: _____ ***Date:*** _____

Code of Conduct

- An official school identification badge will be worn at all times.
- Completion of the *Madison Hospital Short Term Orientation* course is required before going out on the patient area.
- Professional dress standards will be adhered to (i.e., no jeans, open toed shoes, bare mid-drifts). Surgical scrubs are appropriate for observing in the OR only.
- Patient must first give their permission before the student is introduced

Signature of applicant/student: _____ Date: _____

Required immunizations needed for persons involved in clinical rotations at Madison Memorial Hospital:

- Measles
- Mumps
- Rubella
- Tuberculosis screening
- COVID Vaccination

Return this completed form and all other applicable paperwork to:

Medical Staff Office
450 E Main, PO Box 310, Rexburg, Idaho 83440-0310
Direct phone 208-359-6980, Fax 208-359-6984