

MEDICAL STUDENT CLERKSHIP INFORMATION

Please print

Today's Date _____

Name in Full _____ Male _____ Female _____

Clerkship in (Specialty Area) _____

Responsible Physician(s) that will serve as a Sponsoring Physician(s)

From _____ To _____
(Month/Day/Year) (Month/Day/Year)

Level of Education: 2nd yr. 3rd yr. 4th yr. Year/Month of Expected Graduation _____

Name of Medical School _____

Medical School Address _____

Name of Your Dean _____ Dean's Phone Number _____

Date of Birth _____ Place of Birth _____ Citizenship _____

What is the current status of your health? _____

Note: In compliance with Texas Public Health Laws, it is mandatory that personnel provide verification of current status of Tuberculosis, and immune status of Rubella and Hepatitis B before reporting to assigned duties.

Person to notify in an emergency: Name _____

Relationship _____ Phone Number _____

Address _____

I understand that a letter from the Medical School to include the following must be on file with the Medical Staff Coordinator prior to beginning my clerkship:

1. Verify you are a student in good standing.
2. Approval, naming this specific rotation.
3. Specify exact dates of rotation.
4. Verify your health/immunization status.
5. Describe/document specifics of your liability coverage

I hereby certify that the information I submit in this application is complete and correct to the best of my knowledge and belief.

Signature of Medical Student (Print Last Name) Date

VERIFICATION BY MEDICAL STAFF OFFICE

Date received verification/clerkship approval from Medical School _____
 Date received verification of Liability coverage _____

Medical Staff Coordinator Signature Date

STATUS

_____ To Observe Only - NO HANDS ON
 _____ To be under supervision of his/her Sponsoring Physician and/or
 designee

Sponsoring Physician Signature Date

Chief Executive Officer Signature of Designee Date