Graduate Medical Education

Internal Medicine Program Rotation Intake Form

Legacy GME requires 30-days to process all requests

Visiting Trainee Information:

Last Name: _____ *legal name*
First Name: _____ *legal name*
Middle Initial: _____
DOB: _____
SS#: _____ *(xxx-xx-xxxx - last 4 digits only for students)*
Gender: _____
Cell: _____ *(xxx-xxx-xxxx)*
Pager: _____ *If applicable*
Email: _____
Home Institution: _____
Institution Address: _____
Institution Coordinator: _____
Coordinator Email: _____
Coordinator Phone: _____ *(xxx-xxx-xxxx)*
Trainee Type: Medical Student
Current Program Year: _____
Program End Date: _____

Rotation Information - one rotation, per student, per academic year:

Legacy Rotation: Choose one
Legacy Preceptor: To Be Determined - Program Director: Paula Folger, M.D.
Legacy Rotation Site: ☐ **Emanuel** ☐ **Good Samaritan**
Rotation Start-Priority: _____
Rotation Start-Alternate: _____
Prior Epic Experience: YES ◯ NO ◯

Please provide a brief personal statement (limit 650 characters):

For Internal Medicine Student Rotations:

Audition Rotation: YES ◯ NO ◯
Trainee required remediation and/or failed a clinical course rotation: YES ◯ NO ◯
Trainee is in good standing and is qualified to do a clinical rotation: YES ◯ NO ◯
Future Plans? _____

PLEASE RETURN YOUR COMPLETED FORM TO: **QUESTIONS:**

LEMC/LGSMC Internal Medicine ICU/Wards — Traci Aul ..... taul@lhs.org — Phone: (503) 413-7590

HOME INSTITUTION INFORMATION

This page to be completed by the trainee's Program Director or Dean

The trainees's home institution is responsible for verifying and maintaining evidence and documentation of the administrative requirements for each trainee as established under Oregon Administrative Rules 409-030-0100 and will provide Legacy Health with documentation of the below requirements upon request.

I attest, _____, does meet the below requirements for training at Legacy Health.
(print trainee name)

Is in good standing, qualified to do clinical rotations, and not on remediation or probation in their training/education program.	Yes No
Has documented proof of vaccinations (per CDC guidelines): Hepatitis B (Hep B), measles, mumps and rubella (MMR), tetanus, diphtheria, pertussis (Tdap), and varicella. Polio and influenza (seasonal flu) are recommended.	Yes No
Has documented proof of Tuberculosis (TB) screening in accordance with CDC guidelines.	Yes No
Has documented proof of 10-panel drug screen, which must include screens for the following eight substances: Amphetamines, including methamphetamines; Barbiturates; Benzodiazepines; Cocaine; Marijuana; Methadone; Opiates; Phencyclidine.	Yes No
Has documented proof of Criminal Background Check: Must include social security number trace, state/national criminal background history, sex offender registry check, and OIG LEIE check.	Yes No
Has documented proof of CPR/Basic Life Support (BLS) for healthcare providers. It is recommended that trainings comply with the American Heart Association standard.	Yes No
Is covered by professional liability insurance coverage and general liability insurance coverage, or a combined policy that includes professional and general liability coverage, valid in the State of Oregon, for a minimum of $1 million per occurrence and $3 million per aggregate. The coverage must remain in place for the entire duration of each placement. *Please provide proof*	Yes No
Has major medical insurance, valid in the State of Oregon, which will be in effect during the requested rotation.	Yes No
The trainee is a U.S. citizen or has a valid visa to work in the United States.	Yes No

Name of Home Institution *(Please print)*

X

Signature of Program Director or Dean | Printed Name | Date