GRADUATE MEDICAL EDUCATION PROGRAM REQUIREMENTS
All returning learners

In preparation for completing this Clinical Rotation Request, learners must review the following documents available on our Providence Clinical Educational Rotations website:

- Compliance Packet
- HIPPA
- Providence Code of Conduct

After reviewing the documents, complete all information requested in this form, making sure all signatures, initials, and dates are filled in. Take note of what is to be included in the 'complete packet' and send all documents in one email. We request a lead time of **4 weeks** to process the application due to HR Student Affiliation requirements.

In an effort to reduce paperwork, Providence Health & Services will accept the signed Program Attestation (page 3) from your program/school in lieu of documentation noted. Please note that COVID and annual influenza vaccinations are required unless you have a signed Providence declination form on file with your school. Providence reserves the right to require the documentation, if deemed necessary, and you must produce it within 1 day of the request.

Complete Clinical Rotation Request Packet

Working with your school coordinator, submit to the appropriate Providence Program Coordinator**:**

1) Clinical Rotation Request packet;
2) HR Student Affiliation spreadsheet.

You will receive an approval notification from the program office and you cannot start your clinical rotation until you receive this notification.

Returning Clinical Rotation Request
(Students, Residents, Fellows, Non-physician students)

Print or type all information. *A detailed explanation of requirements is included in the Compliance Packet available online. Please complete all forms and submit 4 weeks prior to the beginning of the rotation. Accuracy, timeliness and completeness are the keys to avoiding delays in this process.*

Name: (Last)_____ (First)_____ (MI)_____ Suffix: _____

Gender: M☐ F☐ Other _____ Date of Birth _____ (mm/dd/yyyy) SSN* _____

Home Address: _____ City/State/Zip _____

Email Address: _____ Telephone: _____

Program/School Name: _____ Program Coordinator Name: _____

Program Coordinator email: _____

U.S. Citizenship: Yes ☐ No☐ If no, please indicate current visa status _____

For Residents/Fellows:

NPI _____ Oregon Medical/Dental License _____ DEA/State (if applicable) _____

Dates of Rotation _____ (mm/dd/yyyy) **to** _____ (mm/dd/yyyy)

Preceptor Full Name: _____

Rotation Specialty: _____

Type of Training Program

☐ Physician ☐ Other _____

☐ Advanced Practice Nursing (NP, CRNA, CNS)

☐ Clinical Psychology ☐ Podiatry

Type of Student

☐ Medical Student (year) ___ ☐ Other: _____

☐ Resident (year) ___ ☐ Fellow (year) ____ Anticipated Graduation Year _____

Do you still have a badge from your previous rotation at Providence? ☐ Yes ☐ No

Indicate below any Providence facilities where you will be during this rotation. If you will be on rotation at more than one facility, please indicate where you will be **starting:** _____

☐ Providence Hood River Memorial Hospital
☐ Providence Medford Medical Center
☐ Providence Milwaukie Hospital
☐ Providence Newberg Medical Center
☐ Providence Cancer Center
☐ Providence Portland Medical Center
☐ Providence St. Vincent Medical Center
☐ Providence Willamette Falls Medical Center
☐ Providence Seaside Hospital
☐ Providence Outpatient Clinic _____

**Social Security Number (SSN) is required.*

Program Attestation of Applicant Status

I attest the applicant, _____, for training:
Printed Name of Applicant

1. Is in good standing, qualified to do a clinical rotation, and not on remediation or probation in their training/education program. Yes ☐ No ☐
2. Is covered by professional liability insurance, valid in the State of Oregon, for the duration of each placement, as determined in school affiliation agreement on file. Yes ☐ No ☐
3. Has major medical insurance coverage, valid in the State of Oregon that will be in effect during the requested rotation. Yes ☐ No ☐
4. Has completed TB exposure screening, annual influenza vaccination, Measles, Mumps, Rubella (MMR) and Varicella immunizations, and Hepatitis B vaccination, Covid-19 vaccination and Tetanus, Diphtheria, Pertussis (Tdap) vaccine. Yes ☐ No ☐
5. Has passed a criminal background check, which includes SSN trace and queries of state and national criminal background history, screen of OIG List of Excluded Individuals and Entities (LEIE) sanctions list and Government Services Agency (GSA) Excluded Parties List System (EPLS), and sex offender registry list. Yes ☐ No ☐
6. Has documented proof of 10-panel drug screen, which is inclusive of the following eight substances: Amphetamines, including methamphetamines; Barbiturates, Benzodiazepines, Cocaine, Marijuana, Methadone, Opiates, Phencyclidine. Yes ☐ No ☐
7. Has a current BLS or ACLS certification for healthcare providers per the American Heart Association standard. Yes ☐ No ☐
8. The trainee has documented proof of Bloodborne Pathogen training (OHSA) and familiarity with OSHA-recommended safety guidelines (including fire and electrical safety; personal protective equipment; hazard communications; and infection prevention practices). Yes ☐ No ☐
9. **For residents and fellows only**:
   - The resident/fellow has an appropriate Oregon Medical or Dental license. Yes ☐ No ☐
   - The resident/fellow is a U.S. citizen or has a valid visa to work in the United States. Yes ☐ No ☐
   - Goals and objectives, rotation length, and supervision expectations of this clinical rotation have been provided in writing to the Providence site director and supervising member. This includes a Program Letter of Agreement if required by the program accrediting body. Yes ☐ No ☐

_____ _____
Signature of Program Representative Program/Institution/School Name

_____ _____
Printed Name of Program Representative Date (mm/dd/yyyy)

***** *This form is used in lieu of providing documentation for learner's background check, drug screen, immunization records and BLS/ACLS certifications. Providence reserves the right to ask for documents for inspection and they must be provided within 1 day.*