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 website:

- Compliance Packet
- HIPPA Privacy & Security: What You Need to Know
- Providence Code of Conduct

Then, complete all information requested, making sure all signatures, initials, and dates are filled in. Take note of what is to be included in the 'complete packet' and compile it as **one pdf attachment**. We request a lead time of **4 weeks** to process the application.

In an effort to reduce paperwork, Providence Health & Services will accept the signed Program Attestation (page 3) from your program/school **in lieu** of the background check, 10 panel drug screen, health screen verification and BLS or ACLS certification documents. Please note this must be completed and signed by the School/Program Director. If you choose to use the Program Attestation, please note that 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

Please send all documents in this request packet as **one pdf attachment.**

Option 1:

- ☐ Clinical Rotation Request (pages 2 – 3); inclusive of the Program Attestation

OR

Option 2:

- ☐ Clinical Rotation Request (pages 2, omitting page 3)
- ☐ Background check results: to include Social Security Number trace, OIG sanctions list and GSA/EPLS, criminal history and Sex offender registry.
- ☐ 10-panel drug screen results which is inclusive of the following eight substances: Amphetamines, methamphetamines; Barbiturates, Benzodiazepines, Cocaine, Marijuana, Methadone, Opiates, Phencyclidine.
- ☐ Health Screen verification, which includes a TB exposure screening, annual influenza vaccination, Measles, Mumps, , Rubella (MMR), Varicella immunizations, Hepatitis B vaccination and Tetanus/ Diphtheria/ Pertussis (Tdap) vaccine.
- ☐ BLS or ACLS certification documentation

Working with your school coordinator, submit the completed Clinical Rotation Request packet to the appropriate Providence Program Coordinator**.**

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

PROVIDENCE Health & Services

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 _____ SSN* _____
(mm/dd/yyyy)

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, and Advanced Practice Nursing only:

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

Current Degree:
☐ DO ☐ DDS ☐ DMD ☐ DPM ☐ MD ☐ MD, DDS ☐ MD, DMD ☐ MBBS ☐ PA ☐ RN

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

Preceptor Full Name: _____

Rotation Specialty: _____

Type of Training Program
☐ Physician ☐ Other _____
☐ Advanced Practice Nursing (NP, CRNA)
☐ Clinical Psychology ☐ Podiatry

Type of Student
☐ Medical Student (year) ___ ☐ Resident (year) ___ ☐ Fellow ☐ Other: _____

Have you had previous Epic Training? ☐ Yes ☐ No

Have you had previous access to Providence electronic systems? ☐ Yes ☐ No

Have you completed a previous rotation with Providence within the past two years? ☐ Yes ☐ No
If yes, do you still have a badge? ☐ Yes ☐ No

Indicate below any Providence facilities where you will be during this rotation. If you will be 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.*

PROVIDENCE Health & Services

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 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 has an appropriate Oregon Medical or Dental license. Yes ☐ No ☐

   The resident is a U.S. citizen or has a valid visa to work in the United States. Yes ☐ No ☐

   I have provided the goals and objectives, rotation length, and supervision expectations of this clinical rotation 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 Director/Dean Program/Institution/School Name

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

***** *This form can be used in lieu of school or program attestation letter and in lieu of providing documentation for learner's background check, drug screen, immunization records and BLS/ACLS certifications. However, Providence reserves the right to ask for documents for inspection.*