LEHIGH VALLEY HEALTH NETWORK
VISITING MEDICAL STUDENT ELECTIVE APPLICATION
2011-2012

This form does not serve as a formal rotation request. Please follow request guidelines, on or after April 1st, as noted on our website at www.lvhn.org/education.

Part I. To be completed by applicant. *This application will not be complete unless all questions are answered.*

Name _____ **SSN:**

_____ **DOB:** _____ **Male** _____ **Female** _____

Mailing Address _____

School _____ **Class of** _____

Telephone Day _____ **Night** _____

Email Address _____

Department / Specialty _____

Dates _____ **To** _____

Alternate Dates _____ *To* _____ *Or* _____ *To* _____

I will require housing for my rotation. _____ Yes _____ No

I understand that Lehigh Valley Health Network assumes no liability for any personal medical costs incurred by me while I am participating in an elective at LVHN. I have provided a copy of my health insurance card along with the health certification form.

I agree to notify the Lehigh Valley Health Network Division of Education, in writing, at least 30 days prior to my scheduled elective course date, should I be unable to take the elective.

Signature _____ **Date** _____

INSTRUCTIONS:

Please complete the elective application <u>after</u> you have received a rotation approval by the department in which you plan to rotate.

1. The applicant must fully complete Part I, sign and date the application.
2. Upon completion of Part I, the applicant must take the application to the Dean's Office of the Medical School. The Dean of Students, or other authorized official, should completely fill in Part II and apply the institutional seal.
3. The attached Health Certification must be completed by a healthcare professional.
4. Return the completed application to the Office of Student Affairs. The completed application must be received 3 weeks prior to the student beginning the elective rotation.
5. A jpeg photo, suitable for an ID badge, must be electronically submitted to the email address below.

Kelli Ripperger
Office of Student Affairs
Lehigh Valley Health Network
1247 S. Cedar Crest Boulevard, Suite 202.
Allentown, PA 18103
email: Kelliann.Ripperger@lvhn.org

Part II. This section must be completely filled out by the Dean of Students or other authorized official of the applicant's medical school. <u>Students will not be allowed to begin their rotation until all information is received</u>.

1 The student listed in Part I ρ **is** ρ **is not** covered by a school sponsored health insurance policy while participating in this elective.

2 The student listed in Part I ρ **has** ρ **has not** been trained in Universal Precautions, Infection Control and Infectious Disease, General Health Safety including Back Injury, Chemical Safety, and Fire Safety.

3 A written evaluation ρ **will** ρ **will not** be required.
NOTE: Please attach a copy of the school evaluation to this form. All completed evaluations are the responsibility of the medical student.

4. Lehigh Valley Health Network reserves the right to remove any student from an elective at any time. The school will be notified of any such action within one working day.

I certify that _____ is a student in good standing at this medical school and has been approved to participate in the elective specified in Part I of this application.

This student will be in the _____ year of a _____ year curriculum on the dates specified for this elective.

I further certify that the student is covered by liability insurance for all actions taken during this elective at Lehigh Valley Hospital.

Liability Insurance Carrier _____Policy

Number_____Signature

Date _____

Name _____Title

School

School Address School Seal

Please complete the attached Health Certification Form or attach a comparable school immunization document to this application.

STUDENT HEALTH CERTIFICATION

Name:_____
Social Security Number _____ ☐Medical/PA Student

Welcome to Lehigh Valley Health Network. We are dedicated to protecting you and our patients from infectious diseases. To meet the requirements set forth by LVHN and OSHA, you will need documentation for the following immunizations and tests before beginning your experience at LVHN.

** Please note: **The documentation that follows must be provided by a healthcare professional capable of certifying that the following requirements have been met.** ****This form is valid for one year.**

DISEASES* ***(must show documentation of A, B, or C)***		**A) IMMUNIZATION DATES***			**B) DOCUMENTED HISTORY OF DISEASE***	**C) TITERS***	
						Date	**Result**
Hepatitis B		(1)	(2)	(3)			☐ (+) ☐ (-)
Varicella (chickenpox)		(1)	(2)				☐ (+) ☐ (-)
MMR		(1)	(2)				☐ (+) ☐ (-)
Measles (rubeola) (Only one dose required if born before 1957)		(1)	(2)				☐ (+) ☐ (-)
Mumps (Only one dose required if born before 1957)		(1)	(2)				☐ (+) ☐ (-)
Rubella (Only one dose if born before 1957)		(1)					☐ (+) ☐ (-)
Influenza (Required if student participating Oct-April)		(1)					
Diphtheria/Tetanus (Not required but please document last dose and update if necessary)							
Other Vaccines -	BCG						
not required but please document date if applicable							

Must have documentation of: A) appropriate number of immunizations, or B) documented history of disease or C) positive titer.

***Per CDC recommendations, 3 doses of Hepatitis B, 2 doses of varicella, and 2 doses MMR immunizations or documentation of disease are REQUIRED for proof of immunity.**

In order to protect our patients, staff, and visitors, please review the following section carefully. If you or anyone in your household/family has shown any of the following symptoms/illnesses within three days of the program, **please refrain from participating until your doctor has released you to do so:**

vomiting rash conjunctivitis (pink eye)
cough cold sore (fever blister) cold or flu strep infection
fever Impetigo diarrhea

I hereby certify that_____ is free from communicable diseases in the communicable state. This individual does not possess any health handicap or other physical limitation which would interfere with his or her ability to satisfactorily perform the duties to which assigned within the scope of duties normally performed in the role identified above.
I also certify that the immunization/immunity/testing requirements, as listed above, have been fulfilled.

Health Care Provider's Signature (required) _____

Health Care Provider's Name (print) _____

Phone number_____ **Date** _____

Tuberculosis: Two TB skin tests within 12 months prior to your start date at LVHN, and one of which is within 3 months of the start date:

Date #1:____/____/____ Result ☐ (+) ☐ (-)
Date #2:____/____/____ Result ☐ (+) ☐ (-)

Or if applicable

Date of first positive TB skin test: ____/____/____ ☐ INH Therapy ☐ Yes ☐ No
Chest x-ray within the past 6 months: ____/____/____ Result ☐ nl ☐ abnl

I hereby certify that_____ is free from communicable diseases in the communicable state. This individual does not possess any health handicap or other physical limitation which would interfere with his or her ability to satisfactorily perform the duties to which assigned within the scope of duties normally performed in the role identified above. I also certify that the immunization/immunity/testing requirements, as listed above, have been fulfilled.

Health Care Provider's Signature_____

Health Care Provider's Name (print)_____

Phone number_____

Date:_____

Medical Students must return this form to: Kelli Ripperger, 1247 S. Cedar Crest Boulevard, Suite 202, Allentown, PA 18103.

Rev. 12/11