

**LEHIGH VALLEY HEALTH NETWORK**  
**VISITING MEDICAL STUDENT ELECTIVE APPLICATION**  
**2009-2010**

*\*Must be used for all rotations beginning June 2009*

**PART I: Instructions**

**A. Approval Process**

1. All elective rotation requests must be submitted by email to **Sherri\_S.White@lvh.com**. Please allow 4-6 weeks for processing. Phone requests will not be processed.

2. Do not request an elective rotation unless you are in possession of your AY 09-10 rotation schedule. Request only those rotations that you are certain your schedule allows.

**Include the following information with your email request:**

- **Name**
- **School/Year (e.g. LECOM / 2010)**
- **Start Date (Monday)**
- **End Date (Friday)**
- **Alternate Dates if applicable**
- **Department / Sub-specialty (e.g. Medicine / GI)**
- **Phone #**
- **Do you require housing?**

3. Students will receive rotation approval via email notification. The elective application will be attached for completion. The elective application may also be downloaded from our internet site: [www.lvh.org](http://www.lvh.org). Locate "Mission" at the bottom of the page and click on Education, then Medical Student Rotations.

**B. Application Process**

1. All applications must be accompanied by a letter of good academic standing by the sending medical school indicating the following:

- Student is fully covered by liability or malpractice insurance through their medical school.
- Student is covered by personal health insurance.

2. LVHN's elective application must be completed in full (Parts I, II, III, and IV) and sent to the Division of Education three weeks prior to the approved rotation start date. Incomplete applications will be returned to the sending institution. A school version of the elective application will not be accepted.

3. All LVHN health certification requirements must be documented either on the attached form (Part III) signed by a healthcare provider, or in a corresponding school document signed by a healthcare provider.

4. A jpeg student photo must be sent via email, following the submission of the elective application.

5. An incomplete application will result in cancellation of the requested rotation.

**C. Confirmation Process**

1. Students will receive an email confirmation with arrival, housing, and orientation documents mid-week prior to the rotation start date.

*For more information about elective rotations available at LVHN, visit [www.lvh.org](http://www.lvh.org).*

2009-2010

LEHIGH VALLEY HEALTH NETWORK  
MEDICAL STUDENT ELECTIVE APPLICATION

*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:**

**The completed application must be received no earlier than 45 days prior to the scheduled starting date of the elective. Rotation requests must be emailed and are processed on a first come, first served basis.**

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 Division of Education. The completed application must be received prior to the student beginning the elective rotation.

Sherri White  
Division of Education, Medical Education Development  
Lehigh Valley Health Network  
1247 S. Cedar Crest Boulevard, Suite 202  
Allentown, PA 18103  
email: Sherri\_S.White@lvh.com

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

- 1 The student listed in Part I  **is**  **is not** covered by a school sponsored health insurance policy while participating in this elective.
- 2 The student listed in Part I  **has**  **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  **will**  **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 and submit with this application.

**HEALTH CERTIFICATION FOR EDUCATIONAL PROGRAMS**

NAME: \_\_\_\_\_  
 Social Security Number \_\_\_\_\_  
 Department or Program \_\_\_\_\_

- Resident
- Medical Student
- PA Student
- Nursing Student
- Other \_\_\_\_\_

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 Policies and OSHA, you will need documentation for the following immunizations and tests before beginning your experience at LVHN. The Documentation that follows must be provided by a healthcare professional capable of certifying that the following requirements have been met.

DISEASES	IMMUNIZATION DATES*			DOCUMENTED HISTORY OF DISEASE*	TITERS*	
					Date	Result
Hepatitis B (for those with potential blood/body fluid contact)	(1)	(2)	(3)			<input type="checkbox"/> (+) <input type="checkbox"/> (-)
Varicella (chickenpox)	(1)	(2)				<input type="checkbox"/> (+) <input type="checkbox"/> (-)
MMR	(1)	(2)				<input type="checkbox"/> (+) <input type="checkbox"/> (-)
Measles (rubeola) (Only 1 dose required if born before 1957)	(1)	(2)				<input type="checkbox"/> (+) <input type="checkbox"/> (-)
Mumps	(1)					<input type="checkbox"/> (+) <input type="checkbox"/> (-)
Rubella	(1)					<input type="checkbox"/> (+) <input type="checkbox"/> (-)
Diphtheria/Tetanus Not required but please document last dose and update if necessary						
Other Vaccines						
not required but please document date if applicable	BCG					

\*Must have documentation of appropriate number of immunizations, or documented history of disease or positive titer.

**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: Sherri White, 1247 S. Cedar Crest Boulevard, Suite 202, Allentown, PA 18103