GRAND RAPIDS MEDICAL EDUCATION PARTNERS

in affiliation with Michigan State University College of Human Medicine

Section I: To be completed by the Visiting Student

Name _____ **Medical School** _____
(First MI Last)

Address _____ **School Address** _____

_____ _____

Phone _____ **School Contact Person** _____

Email _____ **School Contact Phone** _____

Last 4 Digits of SSN [ ] **School Contact E-mail** _____

Selective/Elective Date Requests (*all date requests must start and end on a weekday*)

1st Choice _____ Dates:_____ to _____

2nd Choice _____ Dates:_____ to _____

3rd Choice _____ Dates:_____ to _____

Are you considering applying to one of our residencies? ☐ Yes ☐ No ☐ Unsure

If yes, in which residency program are you interested? _____

****Please note: If applying for a rotation in **pediatrics**, **plastic surgery**, or **radiology**, a personal statement about your interest in that specialty and in Grand Rapids as a location must be included with your application.****

Section II: To be completed by the student and verified by the medical school

Expected medical school graduation date: _____

Have you passed USMLE Step 1 OR COMLEX Level 1 Exam? ☐ Yes ☐ No

Score_____ Number of times taken_____

Have you passed USMLE Step 2 Clinical Knowledge OR COMLEX Level 2 Exam? ☐ Yes ☐ No

Score_____ Number of times taken_____

Have you passed USMLE Step 2 Clinical Skills Exam OR COMLEX Clinical Skills Exam? ☐ Yes ☐ No

Number of times taken_____

Office Use Only

Approved_____ Date Coming_____

Type of Learner_____

Application Processed_____

Given to HR_____

Are you currently authorized to be in and study in the United States? ☐ Yes ☐ No

If not a U.S. citizen or permanent resident, what is the visa status that permits you to live and study in the United States? _____(**attach copy of passport & visa to application**)

Have you completed the following required Joint Commission/HIPAA educational requirements?

☐ Yes ☐ No ☐ Unknown Date last completed_____

Have you completed the following required training within the 12 months preceding the requested elective(s)?

☐ Yes ☐ No ☐ Unknown Universal Precautions Date late completed_____

☐ Yes ☐ No ☐ Unknown Blood Borne Pathogens Date last completed_____

I authorize my Dean's office, Institutional Compliance Officer or physician to provide all verification and health information in Sections II and III of this application.

_____ _____

Student Signature ***Date***

Section III: To be completed by medical school Dean of Student Affairs or designee

☐ Yes ☐ No The above named student is a student in good standing.

☐ Yes ☐ No S/he is approved to take the requested elective(s).

☐ Yes ☐ No S/he will be covered by home medical school liability insurance while rotating at MSU/CHM.

Please state per instance / aggregate insurance amount:_____

☐ Yes ☐ No S/he will be paying tuition and receiving credit for this elective at home medical school.

Our records show that this student has:

☐ Yes ☐ No ☐ Unknown Personal health coverage which will be in effect during this elective.

☐ Yes ☐ No ☐ Unknown This student has acute or chronic health problems or special accommodations that need to be in place to successfully complete this elective.

If yes, explain _____

_____

I verify that all information in Sections II and III of this application are accurate.

_____ _____ _____

Signature ***Printed Name, Dean of Student Affairs (or designee)*** ***Date***

Section IV: To be completed by the Visiting Student

BACKGROUND INVESTIGATION INFORMATION – VISITING LEARNERS

Print Full Name _____

Other Names Used _____

Date of Birth * _____ **Social Security Number** _____

Drivers License Number _____ **State/Country** _____

Home Address History:

Current home address first – Include city, county, state, zip, country, and dates at each address (Must have at least prior 10 years of home address):

Address, City, County, State, Zip, Country	**Dates at address** (*List current address first)*
1.	
2.	
3.	
4.	
5.	

Name:_____

6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	
15.	

Name: _____

Employment History/Information

1. Name of employer _____

Name of supervisor _____

Address, city, state, zip, country _____

Area code-Phone number _____ Dates of employment _____

2. Name of employer _____

Name of supervisor _____

Address, city, state, zip, country _____

Area code-Phone number _____ Dates of employment _____

3. Name of employer _____

Name of supervisor _____

Address, city, state, zip, country _____

Area code-Phone number _____ Dates of employment _____

4. Name of employer _____

Name of supervisor _____

Address, city, state, zip, country _____

Area code-Phone number _____ Dates of employment _____

5. Name of employer _____

Name of supervisor _____

Address, city, state, zip, country _____

Area code-Phone number _____ Dates of employment _____

Name: _____

6. Name of employer _____

Name of supervisor _____

Address, city, state, zip, country _____

Area code-Phone number _____ Dates of employment _____

7. Name of employer _____

Name of supervisor _____

Address, city, state, zip, country _____

Area code-Phone number _____ Dates of employment _____

8. Name of employer _____

Name of supervisor _____

Address, city, state, zip, country _____

Area code-Phone number _____ Dates of employment _____

9. Name of employer _____

Name of supervisor _____

Address, city, state, zip, country _____

Area code-Phone number _____ Dates of employment _____

10. Name of employer _____

Name of supervisor _____

Address, city, state, zip, country _____

Area code-Phone number _____ Dates of employment _____

*Date of Birth to be used exclusively for record checking purposes and will not be used for any other purposes.

Name: _____

VISITING LEARNER DISCLOSURE AND AUTHORIZATION FOR CONSUMER REPORT

To Visiting Learners and Applicants for the Visitor Learner Rotation:

Grand Rapids Medical Education Partners may obtain "consumer reports" concerning visiting learners and applicants for the visiting learner rotation from time to time. Consumer reports may include information about one's credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics and mode of living, and may include credit reports, background check reports, and criminal record reports. Grand Rapids Medical Education Partners will use these reports to determine an applicant's eligibility to participate in the visiting learner program.

We ask you to authorize Grand Rapids Medical Education Partners to obtain one or more consumer reports concerning you from a consumer reporting agency. To do so, please sign the authorization statement below.

AUTHORIZATION

I authorize Grand Rapids Medical Education Partners to request and obtain, from time to time, one or more consumer reports concerning me, to be used for the purpose of determining my eligibility to participate in the visiting learner program. A fax or photocopy of this document will have the same effect as the original document.

Signature: _____

Must be hand signed. Typed electronic signatures cannot be accepted.

Date: _____

Email Address: _____

Phone Number: _____

Visiting Medical Student Checklist

☐ I understand each program has different application requirements and limitations and submission of an application does not constitute approval of rotation request or that I will be granted my top choice elective.

☐ I understand that acceptance for an elective rotation does not guarantee a residency interview in that specialty. Time away from a rotation to interview outside the Grand Rapids area is generally prohibited.

☐ I understand visiting medical students are limited to one four-week rotation in their fourth/final year only and must have successfully completed the basic required clerkship in the discipline of the requested rotation.

☐ The Dean of Student Affairs or designee has verified the information in Sections I and II of my application and has completed and signed Section III. I understand my application will not be reviewed unless it is complete.

☐ I understand if I am accepted for a rotation, I will be contacted and asked to complete a mandatory drug screen.

☐ I have attached (or requested from my school) copies of all required documentation, including but not limited to:

- Certificate of Professional Liability Insurance which will provide coverage while rotating with Grand Rapids Medical Education Partners (GRMEP/MSU does not provide liability coverage for visiting students)
  - Student must carry minimum $1 million occurrence and $3 million aggregate liability insurance
- Documentation confirming my immunization history including but not limited to Whooping Cough (DPT or TDaP), MMR, Rubella, Rubeola, Varicella, Hepatitis B, Flu, and TB
  - I hereby release Spectrum Health Occupational Medicine, Grand Rapids Medical Education Partners and Mercy Health Saint Mary's Employee Health Office and its employees, staff and agents from all legal responsibility or liability that may arise from the disclosure of the information set forth relating to my file.

☐ I have attached the credit card form (above) for my $250 non-refundable application fee
(application fee only charged if student is accepted/confirmed for a rotation)

☐ If accepted for a rotation at GRMEP/MSU, the student agrees to the following:

- Student will arrange his/her own housing and transportation.
- Student will complete any required institutional and rotation-specific orientations.
- Student will wear GRMEP and hospital issued ID badge(s); short, white lab coat; and adhere to rotation-specific dress code at all times.
- Student will comply with all GRMEP and specific training site policies.
- Student will perform assigned duties to the best of his/her ability and work assigned shifts.
- Student will maintain patient confidentiality by following all HIPAA regulations.
- Student will provide his/her preceptor with his/her school's evaluation form and instructions on returning it.
- Any rotation changes or cancellations should be communicated to GRMEP as soon as possible and within 60 days of the rotation start date. Students should not contact preceptors independently.

☐ Submit completed application **no less than 90 days in advance of rotation start date** via mail to:
Tracy Olson, 945 Ottawa Ave NW, Grand Rapids, MI 49503.
Email to tracy.olson@grmep.org or fax to 616-732-6257 or upload to ***VSAS*** as part of your required documents.

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Visiting Learner Non-Refundable Application Fee — **$250.00**

****Application fee subject to change****

Med Student VL 5180-199

Learner Name: _____

Requested Rotation: _____

Dates of Rotation: _____

Credit Card Number: _____

CVV / Security Number: _____

Credit Card Expiration: _____

Learner Signature: _____

Mail to:

Tracy Olson
MSU Citywide Scheduler
Grand Rapids Medical Education Partners
945 Ottawa Ave NW
Grand Rapids, MI 49503

Fax to: **616.732.6257**

Confidentially email to: **tracy.olson@grmep.org**

**NOTE: Credit cards (Visa, MC), money orders, or cashier's checks will be accepted.
****No Discover or AMEX cards, personal checks, or cash.**