

## The MetroHealth System Student Application Requirements

Students must provide the following documents/information prior to beginning a rotation at any of the MetroHealth System facilities.

- Completed Student Application Form**
- Completed Clerkship and Elective Completion Page** (Signature of school official required)
- Copy of USMLE or COMLEX Test Results** (Minimum 220 on USMLE Step 1 or passing score on COMLEX required)
- A Certificate of Malpractice Insurance Coverage** (The limits of liability must be no less than \$1,000,000 per occurrence / \$3,000,000 annual aggregate.)
- Valid, clear background check or a letter from the medical school attesting to the presence of a valid, clear background check, that meets the following criteria:**
  - It is a nationwide background check spanning at least the previous seven (7) years
  - The background check was completed no more than one (1) year prior to the start of their educational program with the school
  - The background check was performed by a vendor accredited by the NAPBS
- Personal Statement**
- PPD test administered within the past 12 months** (If the result of the TB screening is positive, a chest x-ray administered within the past 12 months will also be required)
- Seasonal Flu Vaccine** – Required for all rotations between November and April
- Documentation of the following immunizations is PREFERRED, but not required. Students assume the risk of exposure to such diseases if immunizations are not secured and maintained over the course of their Program.**
  - Hepatitis B** (series of 3 immunizations or titers)
  - Measles, Mumps and Rubella** (series of 2 immunizations or titers)
  - Varicella (Chicken Pox)** (documented history, immunization or titer)
  - Diphtheria/tetanus** (Record of booster within the past 10 years)

**Return ALL the above documents to the Attention of:**

**Kim Hatch**  
**GME Program Assistant**  
MetroHealth Medical Center  
2500 MetroHealth Drive, Cleveland, OH 44109  
**Phone: 216-778-5369 Fax: 216-778-5862**  
[khatch@metrohealth.org](mailto:khatch@metrohealth.org)



## The MetroHealth System Medical, Dental and Podiatry Student Application

All Medical, Dental and Podiatry students completing rotations at the MetroHealth System MUST complete this application PRIOR to the assigned rotation/elective. All students must be in good standing with their medical school and in their final year with all cores completed to participate in the student program at MetroHealth Medical Center. Failure to comply with The MetroHealth system policies & procedures & conditions for rotations will result in the suspension of said rotation and the inactivation of all electronic access.

### Demographic Information

**Please Print Legibly**

New to MetroHealth?  No  Yes

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Male  Female YR in School: \_\_\_\_\_ Social Security #: xxx-xx-\_\_\_\_\_ DOB: \_\_\_\_\_

Address \_\_\_\_\_ Apt # \_\_\_\_\_ Phone # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Email \_\_\_\_\_

### Emergency Contact Information

Name & Relationship of Contact: \_\_\_\_\_

Phone: \_\_\_\_\_

### Medical School Information

Name of Medical School \_\_\_\_\_ Expected Grad Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Contact Person at School \_\_\_\_\_ Phone # \_\_\_\_\_

Contact Person Email: \_\_\_\_\_

### Elective Information

Elective Requested: \_\_\_\_\_ Start Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ End Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Elective Requested: \_\_\_\_\_ Start Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ End Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Elective Requested: \_\_\_\_\_ Start Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ End Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

★ How many electives would you like to do at MetroHealth: \_\_\_\_\_ (maximum of 3 Electives)

The following departments **DO NOT** accept international medical students: Emergency Medicine, Family Medicine, Hematology/Oncology, OB/GYN, Ophthalmology, Pediatrics and Radiology

**Please have this page completed by your Dean's Office**

**Core Clerkships Completed**

Clerkship Name and Location	Inpt	Outpt	Dates
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Electives Completed**

Elective Name and Location	Inpt	Outpt	Dates
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

**TO BE COMPLETED BY THE DEAN OF THE STUDENT'S SCHOOL**

Student Name: \_\_\_\_\_ Grad Year: \_\_\_\_\_

The above name student is in good standing at this institution. The student will pay tuition at this school during the period indicated. Malpractice insurance does cover the student away from this school. Personal health coverage is in effect away from the school. The student is authorized to take this elective.

Name and Mailing Address to send completed school evaluation for student:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Signature of Dean or School Official verifying above clerkships and electives is required**

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

(School seal must be imprinted over signature)



How did you hear about the medical student opportunities at MetroHealth (select all that apply)?

- Internet                       Medical School Registrar/Dean                       Peers
- Medical Student Fair (Location: \_\_\_\_\_)                       Other: \_\_\_\_\_

As employers/government contractors, we comply with government regulations and affirmative action responsibilities. To help us comply with government record keeping, reporting and other legal requirements, please fill out this Self Identification Sheet. This data is for analysis and record keeping purposes only.

**Race/Ethnic Group – Used for Diversity Data**

White (not of Hispanic origin)                       Black (not of Hispanic origin)                       Hispanic

Asian or Pacific Islander                       American Native                       Indian Subcontinent                       Other \_\_\_\_\_

Fluent in other languages: \_\_\_\_\_

All students are required to wear a MetroHealth System ID badge. This ID badge must be visible at all times while on the MH Campus. You will obtain your ID Badge during your student orientation. You will be required to present one of the following forms of identification to obtain your MetroHealth ID Badge:

- a) Valid Driver’s License (Ohio, other states, international)
- b) State Identification Card (obtained through the license bureau)
- c) Valid Passport

I understand that MetroHealth Medical Center assumes no liability for any medical costs incurred by me while I am participating in an elective at MetroHealth Medical Center. I agree to notify MetroHealth Medical Center 30 days prior to my scheduled elective dates should I be unable to participate in the elective. I understand that confirmation of acceptance into any elective cannot be given until MetroHealth Medical Center has notified me. I also understand I am allowed to participate in a maximum of three electives at MetroHealth Medical Center.

**I certify that all information contained in this application is true and correct.**

\_\_\_\_\_

**Student Signature** **Date**

**ACCEPTANCE OF TERMS to rotate through MetroHealth**

I hereby authorize the release of my background check, drug screen, vaccinations, PPD/TB results and/or chest x-ray findings to the MetroHealth Graduate Medical Education affiliate coordinator, Employee Health Department, and/or the Department Coordinator(s) of The MetroHealth System as part of the rotation requirements.

**I have read the application and agree to comply with the rules and regulations of the MetroHealth System.**

\_\_\_\_\_

**Student Signature** **Date**

## EMERGENCY INFORMATION

The MetroHealth System is committed to providing a safe environment. All employees must work together to maintain a safe workplace. This document was designed to assist with this task.

<p><b><u>Emergency Hospital Codes</u></b></p> <ul style="list-style-type: none"> <li>• Fire Code Red</li> <li>• Fire Alarm System not working Red System Alert</li> <li>• Infant &amp; Child missing/abducted/eloped Code Adam</li> <li>• Missing Adult Patient Code Brown</li> <li>• Medical Emergency/Adult Code Blue</li> <li>• Medical Emergency/Pediatric Code Blue (Pediatric)</li> <li>• Neonatal Medical Emergency Code Pink</li> <li>• Disaster Code Yellow</li> <li>• Severe Weather Code Gray</li> <li>• Bomb/Bomb Threat Code Black</li> <li>• Hazardous Material Spill/Release Code Orange</li> <li>• Violent Patient/Combative Code Violet</li> <li>• Person with Weapon/Hostage Situation Code Silver</li> </ul>	<p><b><u>Emergency Phone Extensions</u></b></p> <p>81111 (Hospital Operator)</p> <p>83333 (MH Police Department) Urgent</p> <p>83000 (MH Police Department)</p>	<p><b><u>Situation</u></b></p> <p>Code Red</p> <p>Code Orange</p> <p>Radioactive Incident</p> <p>STAT page</p> <p>Code Blue</p> <p>Code Pink</p> <p>Code Gray</p> <p>Assault/Theft in progress</p> <p>Code Brown</p> <p>Code Violet</p> <p>Code Silver</p> <p>Code Adam</p> <p>Code Black</p> <p>Unusual odor and/or smoke</p> <p>Suspicious Person (s)</p> <p>Escort to Car</p>
<p><b><u>When Reporting an Emergency</u></b></p> <p>Provide the following information about the location:</p> <p style="padding-left: 40px;">Building Clinic/Department</p> <p style="padding-left: 40px;">Floor Room Number</p> <p>Wait for the message to be repeated</p> <p>For security emergencies, leave the phone off the hook so the situation can be monitored</p>	<p><b><u>Fire Safety</u></b></p> <p><b>If you see fire and smoke (Code Red)</b></p> <p>R – <b>Relocate</b> or rescue patients</p> <p>A – <b>Activate</b> alarm or dial 81111</p> <p>C – <b>Confine</b> fire/smoke and close doors</p> <p>E – <b>Extinguish fire if possible and Evacuate</b></p>	
<p><b><u>If you receive blood or body fluid contamination</u></b></p> <p>Clean the exposure site.</p> <p>Notify your supervisor</p> <p>Complete an Employee Injury Report Form</p> <p>Call the Employee Health Clinic at 85365 between 7:30 am-4: 30 p.m. M-F.</p>	<p><b><u>Extinguish</u></b> – use extinguisher in your work area located at exits (Do <u>not</u> use extinguisher on a person)</p> <p>P – Pull the pin</p> <p>A – <b>Aim</b> at the base of the fire</p> <p>S – <b>Squeeze</b> the handle</p> <p>S – <b>Sweep</b> from side to side</p> <p><b><u>Material Safety Data Sheet (MSDS)</u></b></p> <p>MSDS manuals are available in departments where hazardous chemicals are used. It is important to read a MSDS sheet before using the chemical.</p>	
<p><b><u>Electrical Safety</u></b></p> <p>Patient care equipment is inspected by Clinical Engineering regularly. Each piece of equipment is dated and labeled by the technician. If patient care equipment is not operating properly remove it and notify the charge nurse and Clinical Engineering at 83500.</p> <p><b><u>Preventive measures</u></b></p> <ul style="list-style-type: none"> <li>• Adapters, 3-prong converters and extension cords should not be used.</li> <li>• Facilities Management at 85566 must inspect patient or employee owned equipment before use.</li> </ul>	<p><b><u>Cell Phones</u></b></p> <p>Use of cellular phones, mobile radios, and other portable transmitters is permitted inside designated areas within The MetroHealth System. Cell phones must be in the “vibrate” position. These devices may interfere with patient care equipment. Call MH Police Department at 83000 if a problem is encountered.</p> <p><b><u>ID Badge</u></b></p> <p>Employees must wear their MetroHealth identification badge at all times.</p>	

Employees are responsible for complying with all The MetroHealth System policies. The manuals listed below are available on the MetroHealth Information Village (MIV) and should be reviewed. If you do not have access to the MIV, ask your manager for the location of the manuals in your department. It is also important to ask your supervisor about department specific manuals. The Hospital Safety Manual is available in your department.

The MetroHealth System Policy Manual  
 Emergency/Disaster Plan  
 Infection Control Manual

\_\_\_\_\_  
**Student Signature**

\_\_\_\_\_  
**Date**

## The MetroHealth System Confidentiality Acknowledgment Form

I acknowledge my obligation to abide by The MetroHealth System's (MetroHealth) policies, to protect the privacy of MetroHealth's patients and employees, and to refrain from requesting, accessing, photocopying, faxing, discussing, or otherwise using or disclosing any "Confidential Information", including any "Protected Health Information" or other materials belonging to MetroHealth, and its employees and patients for any purpose other than the performance of my specified duties.

I understand that:

1. "Confidential Information" refers to any and all information and materials, irrespective of the media used, whether personal, financial or medical in nature, which belongs to MetroHealth or has been entrusted to MetroHealth, its employees, and agents in the normal course of business operations. This provision incorporates all media including but not limited to, computer based information, faxes, and electronic and paper copy medical records, etc.
2. "Protected Health Information" (PHI) is a subset of Confidential Information defined as individually identifiable health information which:
  - a. Is created or received by MetroHealth, electronically or otherwise.
  - b. Identifies the individual or could be used to reasonably infer the identity of the individual as it relates to the following:
    - i. The past, present, or future physical or mental health condition of an individual,
    - ii. The provision of health care to an individual, or
    - iii. The past, present or future payment for the provision of health care to an individual.

I agree that:

1. I will not access any medical record or other form of PHI in any electronic system or any paper medical record outside of normal business purposes.
2. I will not access my own medical record or other form of my own PHI or that of a family member without following proper procedures [i.e. by request, and accompanied with, the patient's signed authorization, to the medical record department].
3. I will take reasonable precautions to ensure that Confidential Information remains protected from loss, damage, or theft. This includes locking/ logging off of computer workstations when not actively in use as well as locking paper medical records and other confidential documents in file cabinets when not in use.
4. I will not create, generate, or maintain Confidential Information on my personal devices such as a home computer or non-MetroHealth laptop or handheld device.
5. I WILL NOT STORE ELECTRONIC CONFIDENTIAL INFORMATION ON ANY LOCAL HARD-DRIVE (THE "C" DRIVE FOR EXAMPLE AND I UNDERSTAND I NEED TO CONTACT INFORMATION SERVICES IF I AM UNCLEAR WHERE MY LOCAL HARD DRIVE IS) OF ANY COMPUTER, LAPTOP, OR HANDHELD OR OTHER PORTABLE ELECTRONIC DEVICE, INCLUDING BUT NOT LIMITED TO JUMP DRIVES, PDA'S, CD'S, AND DVD'S, UNLESS I AM AUTHORIZED TO DO SO BY, OR IN CONSULTATION WITH, METROHEALTH'S GENERAL COUNSEL.
6. I WILL NOT REMOVE FROM THE PREMISES ANY FORM OF CONFIDENTIAL INFORMATION, INCLUDING BUT NOT LIMITED TO HARD COPIES OF PAPER MEDICAL RECORDS, TRADE SECRET INFORMATION, AND OTHER PROPRIETARY INFORMATION, UNLESS I AM AUTHORIZED TO DO SO BY, OR IN CONSULTATION WITH, METROHEALTH'S GENERAL COUNSEL.
7. I will immediately, upon the termination of my clinical experience with MetroHealth, return any Confidential Information, whether permissibly in my possession or not (except for Benefit Plan and Compensation Information).
8. I understand that maintaining the confidentiality of sensitive material continues after my clinical experience with MetroHealth has ended and that disclosure of Confidential Information after my employment ends may be grounds for legal action.

***I have been fully informed and understand that any violation of MetroHealth's policies or my obligations as agreed to above, could result in the termination of my clinical experience or association with MetroHealth, in civil liability to MetroHealth, its employees and patients, and/or in criminal charges. I understand that the duty of confidentiality of sensitive material continues after my association as a student at The MetroHealth System has ended and that disclosure of confidential information after my association as student can provide grounds for legal action, including possible legal action by patients, families of patients, etc.***

\_\_\_\_\_  
Student Name [please print]

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date