MetroHealth

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 Application**

☐ **Completed Clerkship and Elective Completion Page** (Signature of school official required)

☐ **Copy of USMLE or COMLEX Test Results**

☐ **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 PBSA

☐ **Personal Statement**

☐ **TB Screening Test** (If you have had a positive TB test at ANY time, proof of TB screening within the past 12 months is required. If you have received the BCG vaccine, please specify, and provide documentation.)

☐ **COVID Vaccine** (must have completed vaccine series and be status post 14 days from the last dose)

☐ **Hepatitis B** (series of 3 doses, and titer, if available)

☐ **Measles, Mumps and Rubella** (series of 2 doses, or titer to showing immunity - If you had measles, a doctor's signature is required to confirm the office record.)

☐ **Varicella (Chicken Pox)** (series of 2 doses, or titer to showing immunity)

☐ **Diphtheria/tetanus** (Record of booster within the past 10 years)

☐ **Seasonal Flu Vaccine** (For all rotations between November and April)

<u>Return ALL</u> the above documents to:

GME Student Coordinator
MetroHealth Medical Center
2500 MetroHealth Drive
Cleveland, OH 44109
Phone: 216-778-5369
Fax: 216-778-5862
visitingstudent@metrohealth.org

The MetroHealth System
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

MetroHealth

Clerkships and Electives Completion Summary
Please have this page completed by your Dean's Office

Core Clerkships Completed

Clerkship Name and Location	Inpt	Outpt	Dates
_____	☐	☐	_____
_____	☐	☐	_____
_____	☐	☐	_____
_____	☐	☐	_____
_____	☐	☐	_____
_____	☐	☐	_____
_____	☐	☐	_____

Electives Completed

Elective Name and Location	Inpt	Outpt	Dates
_____	☐	☐	_____
_____	☐	☐	_____
_____	☐	☐	_____
_____	☐	☐	_____
_____	☐	☐	_____

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 always be visible 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 can participate in a maximum of three electives at MetroHealth Medical Center.

I certify that all information contained is 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**

MetroHealth

Confidentiality Acknowledgment Form
Attachment D

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 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 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 <u>any</u> 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, CDs, and DVDs, unless I am authorized to do so by, or in consultation with MetroHealth's General Counsel.
6. I will not remove any form of confidential information from the premises, 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 am aware that text messages are not encrypted. I will avoid sending any patient tracing information through the MetroHealth text paging system or through my personal sell phone.
8. I will not text or email pictures from my personal cell phone or handheld device.
9. Pictures cannot be sent through any system other than EPIC, unless the system is secure.
10. I will return any Confidential Information immediately upon the termination of my association with MetroHealth, whether permissibly in my possession or not (except for Benefit Plan and Compensation Information).
11. I understand that maintaining the confidentiality of sensitive material continues after my association with MetroHealth has ended and that disclosure of Confidential Information after my association 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 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 to The MetroHealth System has ended and that disclosure of confidential information after my association as a student can provide grounds for legal action, including possible legal action by patients, families of patients, etc.

_____

Print Name

_____ _____

Signature **Date**