STUDENT APPLICATION

I. GENERAL INFORMATION

1. _____ Name (Last, First, MI)
2. _____ Home Address/Street
3. _____ City/State/ZIP
4. _____ Date of Birth (Month/Day/Year)
5. _____ Place of Birth
6. _____ Other names used (Maiden, etc.)
7. _____ Personal email address
8. _____ School email address
9. _____ Phone
10. Sex: Male ☐ Female ☐
11. Are You a U.S. Citizen? Yes ☐ No ☐

If Not a Citizen of the U.S., Indicate the Current Status of Your VISA:

_____

_____

II. CURRENT INSTITUTION

1. _____ Institution Name
2. _____ Address/Street
3. _____ City/State/Zip
4. From: _____ To: _____ Dates Attended (month/year)
5. _____ Department Chair/Program Director
6. _____ Type of Program/Degree/Certification Desired
7. _____ Department Chair/Program Dir. Phone

III. PROFESSIONAL LIABILITY INSURANCE INFORMATION (MALPRACTICE)

Please Attach a Copy of Your Current Certificate(s) or Declaration(s) of Insurance from your training institution.

1a. _____ **CURRENT CARRIER NAME**

2a. _____ Address/Street

3a. _____ City/State/Zip

4a. _____ Phone Number

5a. _____ Policy Number

6a. From: _____ To: _____ Dates of Coverage (month/year)

7. Indicate Coverage Type: Claims Based ☐ Occurrence Based ☐

8. Policy Limits: Per Occurrence $_____ Aggregate $_____

IV. SPONSORING PHYSICIAN/PROVIDER

1. _____
   Sponsoring Physician Name
2. _____
   Address
3. _____
   City State Zip
4. _____
   Phone

Sponsoring physician/provider:
This student's performance is my responsibility. I understand that he/she must be identified as a student in all patient contact and that all patients must give oral consent to his/her involvement in care and that all Medical Staff By-Laws are applicable to this affiliation. I have read and will abide by the Medical Staff Policy (MS 1.5) pertaining to supervision of students.
I agree to sponsor and supervise this student during this term of affiliation from _____ to _____

_____ _____
Sponsoring Physician/Provider Signature Date

_____
Print Name