Medical Staff Services
Citizens Memorial Hospital
1500 N. Oakland Avenue, Bolivar, MO 65613
Phone 417-326-6000| fax 417-328-1113| citizensmemorial.com

Dear Student Applicant,

We have received notification that you would like to participate in a clinical rotation at Citizens Memorial Hospital (CMH). We are delighted that you are interested in CMH as a clinic site. Below outlines the details of the application process.

1. **Complete the following pages and return them to Bailey.Abeyta@citizensmemorial.com. Please note that on page 4 your supervising physician/practitioner is required to sign the application to indicate that he/she agrees to the supervision agreement.**

2. **Once the completed electronic packet is received the verification process begins.**

3. **The Director of Medial Staff Services will be notified of your request to participate in clinical rotations at CMH. The Medical Staff Services Office is required to provide approval for all student rotations.**

4. **Once approved, the CMH Medical Staff Liaison will reach out to you to set-up and appointment to meet with you for orientation. Then an agenda will be provided along with a safety video to be viewed.**

5. **When you arrive for orientation you will be provided with an identification badge which is to worn at all times during your clinic rotation. Additionally, a preloaded meal card will be given to you.**

If you have questions please reach out at any time.

Thank you,
Bailey Abeyta
Medical Staff Liaison
Citizens Memorial Hospital
1500 North Oakland
Bolivar, Missouri 65613
Ph. 417-328-6514

Required Documentation and Attachments

Legible photocopies of the following documents MUST be included with your application to Citizens Memorial Hospital. Documents with expiration dates must be current and not have an expiration date within 180 days of the date that your application was submitted. Please initial that you have included copies of the following as applicable.

_____ Current certificate(s) or declaration(s) of insurance

_____ Signed Attestation Agreement (To be signed by student and Physician/Practitioner)

_____ Results of most recent TB skin test (Must be within the last 12 months)

_____ Documentation of Hepatitis B vaccination series

_____ Documentation of Influenza Vaccine For current flu season

_____ Copy of COVID vaccine information

_____ Copy of Criminal Background Check (No more than 180 days form when originally ran)

_____ Proof of completed Fit Test and supply of personal N95 masks

_____ Copy of professional state license (Example: RN License)

_____ Medical students or medical residents must have a letter of good standing from medical school

I have reviewed, completed and/or corrected the attached application and verify that all information is current as of the date of my signature below.

_____ _____

Applicant's Signature Date

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)
   Department Chair/Program Director
6. _____
   Type of Program/Degree/Certification Desired
   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

V. STUDENT ATTESTATION

I request to complete a student rotation at Citizens Memorial Healthcare from _____ to _____ under the supervision of the above physician/practitioner. I understant that in all contacts with patients, family, friends of patients, and staff of Citizens Memorial Healthcare I must wear a name badge identifying myself as a student. Additionally, I understand that I must verbally identify myself as a student and obtain oral permission to attend or be involved in the care of any patient whom I may be assigned. I understand that I must be supervised at all times by a physician/practitioner who is in good standing of Citizens Memorial Healthcare. I have read the Medical Staff Policy 1.5 pertaining to supervision of students and agree to abide by the policy as well as all other hospital polices and procedures during my tenure at Citizens Memorial Healthcare. I agree to report any changes in my student status or health status that would affect my ability to complete my affiliation. I attest that all information furnished is true and complete to the best of my knowledge and furnished in good faith. I understand that willful and significant omissions or misrepresentations may result in immediate termination of my affiliation.

_____
Student Signature

_____
Print Name

VI. CHIEF EXECUTIVE OFFICER OR CHIEF OF STAFF REVIEW

The above application for a medical student rotation has been reviewed and my recommendations are as follows:

_____ Approve rotation from _____ to _____.

_____ Pend application for the following:

_____ Deny application for the following reason:

_____ _____
Signature Date

DOCUMENTATION OR DECLINATION FOR MEDICAL STUDENT
TB SKIN TESTING, HEP B VACCINATION, HEP B TITER, INFLUENZA AND COVID-19 VACCINATION SERIES

ATTESTATION FOR TB SKIN TESTING		
	YES	NO
I attest that I have had a TB skin test yearly and within the last twelve months and the results have been negative.		
I attest that I have had a positive TB skin test, followed by a negative CXR within the last twelve months, and I have not symptoms of active disease.		
I attest that I currently have TB symptoms that are under treatment. I have attached applicable documentation.		

ATTESTATION FOR HEPATITIS B VACCINATION SERIES:		
	YES	NO
I attest that I have had Hepatitis B vaccination series. Date of vaccination:		
If yes, have you had a titer drawn?		
I have not been received the Hepatitis B vaccination and decline to receive the vaccination.		
(*Must sign attached declination)		
ATTESTION FOR RECIPT OF INFLUENZA VACCINATION		
	YES	NO
I attest that I have received the Influenze vaccination.		
I have not received the Influenza vaccination and decline to receive the vaccination.		
(*Must sign attached declination)		
ATTESTATION of RECEIPT OF COVID-19 VACCINATION		
	YES	NO
Medical student has provided a copy of COVID vaccine inforamtion or has submitted an exemption		
Date of vaccinations or declination:		
(*Must sign attached declination)		

Print Name: _____

_____

Signature Date