

Applicant's Name _____

GRMEP Visiting Physician Assistant Student Application Instructions

- For rotation requests occurring in the second half of the 2012-2013 academic year (through June of 2013), requests must be made 90 days in advance.
- For rotation requests occurring in the 2012-2013 academic year, applications are due as follows

July 1 through September 30 April 15
All other months, 90 days prior notice

- Student must complete the application.
- Student must submit Health Information/proof of immunizations.
- Application must be submitted with the following documents:
 - Letter of good standing from your Program Coordinator or School
 - Copy of Professional Liability Insurance Certificate which will provide coverage for Student while rotating at GRMEP (GRMEP does not provide Liability Coverage for visiting students).
 - A copy of Immunization History
 - Proof of current TB
 - Proof of Blood borne Pathogen & Universal Precaution training
 - Proof of HIPAA Training
 - Copy of rotational goals and objectives
 - Completed background investigation release statement (form attached)
 - If certified in ACLS, NALS, ATLS, please provide a copy of the certification
 - \$150 non-refundable application fee. (Does not apply to Students of GRMEP member institutions) Credit cards (AmEx, Visa, MC), money orders, cashier's checks, or business checks from the sponsoring institution will be accepted, **no personal checks or cash.** **application fee subject to change**
- Submit completed application via mail to: Kimberly Longstreet, 1000 Monroe NW Grand Rapids, MI 49503

Or fax to 616-233-6673

GRAND RAPIDS MEDICAL EDUCATION PARTNERS

in affiliation with Michigan State University College of Human Medicine

1000 Monroe Avenue NW | Grand Rapids, MI 49503 | 616.732.6200 | grmep.org

Applicant's Name _____

- Submission of an application does not constitute approval of rotation request.
- You will be notified in writing of the approval status of your application.
- If you have questions, please email kimberly.longstreet@grmep.org

If accepted for a rotation at GRMEP, the Student agrees to the following:

- 1) Student will comply with all GRMEP and specific training site policies.
- 2) Student will perform assigned duties to the best of his/her ability.
- 3) Student will provide his/her own housing.
- 4) Student will complete any required orientations.
- 5) Student will maintain patient confidentiality by following all HIPAA regulations.

Applicant's Signature Date

Printed Name

GRAND RAPIDS MEDICAL EDUCATION PARTNERS

in affiliation with Michigan State University College of Human Medicine

1000 Monroe Avenue NW | Grand Rapids, MI 49503 | 616.732.6200 | grmep.org

Applicant's Name _____

Section I: To be completed by the Visiting Student

Last Name _____ First Name _____ Middle Initial _____

Email address _____

(NOTE: Must be a school/university/institution address, **not** personal, i.e. yahoo, gmail, etc.)

Contact Phone Number _____

School _____ Graduation Date _____

School address _____

School Contact _____ Phone _____

ROTATION REQUEST(s)

Dates

1st Choice _____ TO _____

2nd Choice _____ TO _____

3rd Choice _____ TO _____

GRAND RAPIDS MEDICAL EDUCATION PARTNERS

in affiliation with Michigan State University College of Human Medicine

1000 Monroe Avenue NW | Grand Rapids, MI 49503 | 616.732.6200 | grmep.org

BACKGROUND INVESTIGATION RELEASE STATEMENT

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 each address
1.	
2.	
3.	
4.	
5.	
6.	
7.	

GRAND RAPIDS MEDICAL EDUCATION PARTNERS

in affiliation with Michigan State University College of Human Medicine

1000 Monroe Avenue NW | Grand Rapids, MI 49503 | 616.732.6200 | grmep.org

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: _____

GRAND RAPIDS MEDICAL EDUCATION PARTNERS

in affiliation with Michigan State University College of Human Medicine

1000 Monroe Avenue NW | Grand Rapids, MI 49503 | 616.732.6200 | grmep.org

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 _____

Name: _____

GRAND RAPIDS MEDICAL EDUCATION PARTNERS

in affiliation with Michigan State University College of Human Medicine

1000 Monroe Avenue NW | Grand Rapids, MI 49503 | 616.732.6200 | grmep.org

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

Prior to your Visiting Learner Rotation and as part of the Visiting Learner Application process with Grand Rapids Medical Education Partners, I understand that investigative background inquiries are going to be made on me. I understand that you will be requesting information from various Federal, State, Local and other agencies which maintain records concerning my past activities relating to my driving history, credit, criminal, civil and other experiences. These reports may also include inquiries regarding my educational history and past work experience and performance including reasons for termination of employment.

I authorize, without reservation, any party or agency contacted by this employer or its agents to furnish any of the above mentioned information or any other information requested. I understand that such information may contain my social security number. I release all parties from all liability for any damage that my result from furnishing that information to this company.

I understand that the information generated, received or maintained during and as a result of this investigation will be maintained as confidential information.

A photocopy of this document is considered to be as valid as the original document.

I acknowledge that I have received a copy of my rights under the Fair Credit Reporting Act.

Signature _____

Date _____

Email Address: _____

Phone Number: _____

Name: _____

GRAND RAPIDS MEDICAL EDUCATION PARTNERS

in affiliation with Michigan State University College of Human Medicine

1000 Monroe Avenue NW | Grand Rapids, MI 49503 | 616.732.6200 | grmep.org

Visiting Learner Application Fee **\$150.00**
VL 5590-199

Learner Name: _____

Requested Rotation: _____

Dates of Rotation: _____

Credit Card Number: _____

Credit Card Expiration: _____

Learner Signature: _____

Mail to: **Kimberly Longstreet**
GME Coordinator
Grand Rapids Medical Education Partners
1000 Monroe, NW
Grand Rapids, MI 49503

Confidentially Fax to: **616.233.6673**

GRAND RAPIDS MEDICAL EDUCATION PARTNERS

in affiliation with Michigan State University College of Human Medicine

1000 Monroe Avenue NW | Grand Rapids, MI 49503 | 616.732.6200 | grmep.org

Name _____

I authorize my home Program Director, to release to Grand Rapids Medical Education Partners, all performance and health information necessary to complete SECTION II of this application.

Applicant's Signature

Date

Printed Name

SECTION II - TO BE COMPLETED BY STUDENT'S PROGRAM DIRECTOR

Please provide the following information regarding _____

Printed Student's Name

- YES NO The above-named Student is currently in good standing.
- YES NO The above named Student has the required academic background and necessary skills to participate in the requested rotation and is approved to take the requested rotation.

If there have been any academic/clinical performance, liability, disciplinary, or other problems with this Student, please explain:

The above-named Student completed Universal Precautions Training on _____ and HIPAA training on _____.

Date

Date

(Copies of training must be attached to this application)

_____ agrees to incur the cost of the above-named Student's

Name of Student's School

salary and benefits during his/her rotation(s) at Grand Rapids Medical Education Partners.

_____ agrees to provide professional liability coverage for the

Name of Student's School

above-named Student during his/her rotation at Grand Rapids Medical Education Partners. (Note: Grand Rapids Medical Education Partners does not provide liability coverage for visiting Students)

GRAND RAPIDS MEDICAL EDUCATION PARTNERS

in affiliation with Michigan State University College of Human Medicine

1000 Monroe Avenue NW | Grand Rapids, MI 49503 | 616.732.6200 | grmep.org

Name _____

Professional Liability Insurance

Name of Company: _____

Policy Number: _____

Limit Per Incident: _____

Limit Per Aggregate: _____

Policy Expiration Date: _____

Tail Coverage Included: _____

(A copy of the Professional Liability Insurance must be attached to this application)

I agree to all of the preceding terms and affirm that all submitted information is correct:

Program Director's Signature *Date*

Printed Name

Name _____

**HEALTH ASSESSMENT SUMMARY SHEET
IMMUNIZATION/VACCINE INFORMATION:**

TB TEST #1 Date: _____ Results: _____ mm: _____

TB TEST #2 Date: _____ Results: _____ mm: _____

Annual TB Test Date: _____ Results: _____ mm: _____

****For Positive Testers Only****

Last Positive Test Date: _____

Last Negative Chest X-Ray: _____

Evaluation/Treatment Record: _____

WHOPPING COUGH (DPT or DTaP) _____

RUBELLA TITER _____ HEP B #1 _____

RUBEOLA TITER _____ HEP B #2 _____

VARICELLA TITER _____ HEP B #3 _____

TETANUS _____ HEP B TITER _____

The following are only required if above titers are **non-immune**:

MMR VACCINE DATES #1 _____ #2 _____

VARIVAX VACCINE DATES #1 _____ #2 _____

I have indicated the dates of the corresponding immunizations above and **have attached the documentation supporting these dates.**

Signature: _____

Date

Printed name of health care provider:

Name Title Date

I hereby release Spectrum Health Occupational Medicine, Grand Rapids Medical Education Partners and Saint Mary's Health Care 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 above relating to my file.

Applicant's Signature Date

Printed Name