MetroHealth Medical Center
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

☐ Copy of USMLE or COMLEX Test Results (A passing score on either exam is 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.)

☐ Letter from medical school attesting to the presence of a valid, clear background check

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

☐ Personal Statement (brief) – Emergency Medicine AI and elective, Family Medicine AI & Medicine AI

☐ 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)

☐ Hepatitis B – Series of 3 doses, serology if available.

☐ Measles, Mumps and Rubella – Immunizations or titers. If you had measles, a doctor’s signature is required to confirm the office record.

☐ Varicella (Chicken Pox) – If no documented history, an antibody titer to measure immunity is required.

☐ Diphtheria/tetanus or Tdap – Record of booster within the past 10 years.

☐ Seasonal Flu Vaccine – For all rotations between November and April

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
MetroHealth Medical Center
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: _______ ___

Home Address: ____________________________________________________________  Apt #: ______

City: _______________________________  State: ______________  Zip: ______________

Phone: ___________________________  Email: ________________________________

Medical School Information
Please Print Legibly

Name of Medical School: ________________________________  Expected Grad Date: ___/___/____

Address: ____________________________________________________________

City: _______________________________  State: ______________  Zip: ______________

Contact Person at School: ________________________________  Phone: ______________

Contact Person Email: ________________________________

Elective Request Information

Elective Requested: ____________________________  Start Date: ___/___/____  End Date: ___/___/____

Elective Requested: ____________________________  Start Date: ___/___/____  End Date: ___/___/____

Elective Requested: ____________________________  Start Date: ___/___/____  End Date: ___/___/____

(Students are allowed a 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
Clerkships and Electives Completion Summary
Please have this page completed by your Dean’s Office

Core Clerkships Completed

<table>
<thead>
<tr>
<th>Clerkship Name and Location</th>
<th>Inpt</th>
<th>Outpt</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>___________________________</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>___________________________</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>___________________________</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>___________________________</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>___________________________</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>___________________________</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>___________________________</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>

Electives Completed

<table>
<thead>
<tr>
<th>Elective Name and Location</th>
<th>Inpt</th>
<th>Outpt</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>___________________________</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>___________________________</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>___________________________</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>___________________________</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>___________________________</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>

Part II: TO BE COMPLETED BY DEAN OF STUDENTS SCHOOL

Student Name: ____________________________  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 where 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 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 I.D. which must be visible at all times while on the MH Campus. You will obtain your ID Badge during your student orientation. Note that 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) or a,

b) State Identification Card (obtained through the license bureau) or a,

c) Valid Passport

**Emergency Contact Information**

Name & Relationship of Contact: ____________________________ Phone No. ______________________

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 give 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 is this application is true and correct.

_________________________  __________________________
Signature                                      Date
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.

<table>
<thead>
<tr>
<th>Emergency Hospital Codes</th>
<th>Emergency Phone Extensions</th>
<th>Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Fire</td>
<td>Code Red</td>
<td>Code Red</td>
</tr>
<tr>
<td>• Fire Alarm System not working</td>
<td>Red System Alert</td>
<td>Code Orange</td>
</tr>
<tr>
<td>• Infant &amp; Child missing/abducted/elopeled</td>
<td>Code Adam</td>
<td>Radioactive Incident</td>
</tr>
<tr>
<td>• Missing Adult Patient</td>
<td>Code Brown</td>
<td>STAT page</td>
</tr>
<tr>
<td>• Medical Emergency/Adult</td>
<td>Code Blue</td>
<td>Code Blue</td>
</tr>
<tr>
<td>• Medical Emergency/Pediatric</td>
<td>Code Blue (Pediatric)</td>
<td>Code Pink</td>
</tr>
<tr>
<td>• Neonatal Medical Emergency</td>
<td>Code Pink</td>
<td>Code Gray</td>
</tr>
<tr>
<td>• Disaster</td>
<td>Code Yellow</td>
<td>Code Brown</td>
</tr>
<tr>
<td>• Severe Weather</td>
<td>Code Gray</td>
<td>Code Violet</td>
</tr>
<tr>
<td>• Bomb/Bomb Threat</td>
<td>Code Black</td>
<td>Code Silver</td>
</tr>
<tr>
<td>• Hazardous Material</td>
<td>Code Orange</td>
<td>Code Adam</td>
</tr>
<tr>
<td>• Spill/Release</td>
<td></td>
<td>Code Black</td>
</tr>
<tr>
<td>• Violent Patient/Combative</td>
<td>Code Violet</td>
<td>Code Black</td>
</tr>
<tr>
<td>• Person with Weapon/Hostage Situation</td>
<td>Code Silver</td>
<td>Code Black</td>
</tr>
</tbody>
</table>

When Reporting an Emergency

Provide the following information about the location:
- Building
- Clinic/Department
- Floor
- Room Number

Wait for the message to be repeated

For security emergencies, leave the phone off the hook so the situation can be monitored

If you see fire and smoke (Code Red)
- R – Relocate or rescue patients
- A – Activate alarm or dial 81111
- C – Confine fire/smoke and close doors
- E – Extinguish fire if possible and Evacuate

Extinguish – use extinguisher in your work area located at exits (Do not use extinguisher on a person)
- P – Pull the pin
- A – Aim at the base of the fire
- S – Squeeze the handle
- S – Sweep from side to side

Material Safety Data Sheet (MSDS)

MSDS manuals are available in departments where hazardous chemicals are used. It is important to read a MSDS sheet before using the chemical.

Electrical Safety

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.

Preventive measures
- Adapters, 3-prong converters and extension cords should not be used.
- Facilities Management at 85566 must inspect patient or employee owned equipment before use.

Cell Phones

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.

ID Badge

Employees must wear their MetroHealth identification badge at all times.

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

______________
Signature

______________
Date

April 2016
The MetroHealth System
Graduate Medical Education

Confidentiality & Appropriate Use of PHI Agreement
READ THOROUGHLY

I, ________________________________, rotating in the Department of _______________________, hereby acknowledge that I have an affirmative obligation to protect the privacy of The MetroHealth System patients and employees. I further understand that, as a student, providing specific services to The MetroHealth System, my duty is to refrain from requesting, accessing, photocopying, faxing, discussing, or otherwise using any confidential information or materials for any purpose other than the performance of my specified duties. I also understand that I must refrain from the information systems that I am granted access to for any reason other than my performance (if this is the case) of my specified duties. This includes accessing medical records in any electronic system (EPIC, Muse, OBIX, etc.) or any paper medical record outside of normal business purposes. This includes my own medical record and that of a family member or friend. I also understand that it is necessary to clarify with the patient what I am allowed to discuss with family and friends prior to disclosing medical information.

I have been fully informed and understand that violation of The MetroHealth System Confidentiality Policy (II-5), is a serious matter and the consequences could be the termination of my association with The MetroHealth System.

Finally, I understand that the duty of confidentiality of sensitive material continues after my association as a student, to The MetroHealth System has ended. 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..

I understand and accept the above.

____________________________________________________________________________

Student Signature                  Print name                  Date

ACCEPTANCE OF TERMS to rotate through MetroHealth: I hereby authorize the release of my background check, vaccinations, PPD/TB results and/or chest x-ray findings to the MetroHealth Graduate Medical Education affiliate coordinator, Employee Health Department, &/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