Graybill Medical Group

Student Application

(An application needs to be submitted for each requested rotation)

Please select accordingly: **Shadow only [ ] Clinical rotation/preceptor [ ] Returning Student [ ]**

Requested Physician/Advanced Practitioner **:**

Requested Location/Specialty**:**

Length of Rotation/Start Date: End Date: Hours:

Gender: Male [ ] Female [ ]

Student's Last Name: Student's First Name:

Home Address: City: State: Zip:

Telephone Number: Email address:

Emergency Contact Name: Relationship: Phone:

School: School Contact Name:
School Contact email: School Contact Phone:
Student's Enrolled Program: (MA,NP,PA,etc):

List of criteria to be covered during the rotation:

If you are a returning student, where did you complete your previous rotation?

Student Signature: **Date:**

* Please make sure your school has provided an Affiliation Agreement and current Certificate of Liability before you start your rotation.

CHECK LIST: TO BE COMPLETED BY HUMAN RESOURCES

Clinical Rotation/Preceptor

[ ] Resume
[ ] School Contact Information
[ ] Copy of License/Certifications
[ ] Contract with school
[ ] COI Insurance Rider/Binder
[ ] Malpractice coverage/*NP, PA, DO, MD*
[ ] Privacy Agreement
[ ] Child/Adult abuse reporting
[ ] HIPAA Lawroom
[ ] Set-up NextGen training (if requested by Physician)
[ ] IT form: request Next Gen login & training (if requested by Physician)
[ ] Student Badge

Student Shadow

[ ] Privacy Agreement
[ ] Child/Adult abuse reporting
[ ] HIPAA Lawroom
[ ] School Contact Information if applicable
[ ] Student Badge w/exp date