

LEHIGH VALLEY HOSPITAL AND HEALTH NETWORK
A Major Clinical Campus of Penn State's College of Medicine
MEDICAL / DENTAL STUDENT ELECTIVE APPLICATION FORM

Part I. To be completed by applicant. Please use a separate application form for each desired application form for each elective. This application will not be processed unless all questions are answered.

Name _____
SSN: _____ DOB: _____ Male _____ Female _____
Mailing Address _____
School _____ Class of _____
Telephone Day _____ Night _____
Email address _____
Specialty / Elective _____
Dates _____ To _____
Alternate Dates _____ *To* _____ *Or* _____ *To* _____

I will require housing for my rotation. Yes No

I understand that Lehigh Valley Hospital assumes no liability for any personal medical costs incurred by me while I am participating in an elective at LVH. I have provided a copy of my health insurance card along with the health certification form.

I agree to notify the Lehigh Valley Hospital Center for Education at least one month prior to my scheduled elective course date, should I be unable to take the elective.

Signature _____ Date _____

INSTRUCTIONS:

The completed application must be received no earlier than 45 days and prior to the scheduled starting date of the elective. Applications are processed on a first come, first served basis .

1. The applicant must fully complete Part I, sign and date the application.
2. Upon completion of Part I, the applicant must take the application to the Dean's Office of the Medical School. The Dean of Students, or other authorized official, should completely fill in Part II and apply the institutional seal.
3. The attached Health Certification must be completed by a healthcare professional.
4. Return the completed application to the Center for Education. The completed application must be received prior to the student beginning the elective rotation.

Mailing Address: Sherri White
Division of Education, Medical Education Development
Lehigh Valley Hospital and Health Network
P.O. Box 7017 – Suite 601
Allentown, PA 18105
610-402-2554 Fax: 610-402-2203 email: Sherrri_S.White@lvh.com

Part II. This section must be completely filled out by the Dean of Students or other authorized official of the applicant's medical school. Students will not be allowed to begin their rotation until all information is received.

- 1 The student listed in Part I **is not** covered by a school sponsored health insurance policy while participating in this elective.
- 2 The student listed in Part I **has not** been trained in Universal Precautions, Infection Control and Infectious Disease, General Health Safety including Back Injury, Chemical Safety, and Fire Safety.
- 3 A written evaluation **will not** be required.
NOTE: Please attach evaluation forms to this form on or before the first day of the elective rotation. All evaluations are distributed and returned through the Center for Education.
4. Lehigh Valley Hospital reserves the right to remove any student from an elective at any time. The school will be notified of any such action within one working day.

I certify that _____ is a student in good standing at this medical school and has been approved to participate in the elective specified in Part I of this application.

This student will be in the _____ year of a _____ year curriculum on the dates specified for this elective.

I further certify that the student is covered by liability insurance for all actions taken during this elective at Lehigh Valley Hospital.

Liability Insurance Carrier

Policy Number

Signature _____ Date _____

Name

Title

School

School Address

School Seal

Please complete the attached Health Certification Form and submit with this application.

HEALTH CERTIFICATION FOR EDUCATIONAL PROGRAMS

NAME: _____
 Social Security Number _____
 Department or Program _____

- Resident
- Medical Student
- PA Student
- Nursing Student
- Other _____

Welcome to Lehigh Valley Hospital & Health Network. We are dedicated to protecting you and our patients from infectious diseases. To meet the requirements set forth by LVHHN Policies and OSHA, you will need documentation for the following immunizations and tests before beginning your experience at LVHHN. The Documentation that follows must be provided by a healthcare professional capable of certifying that the following requirements have been met.

DISEASES	IMMUNIZATION DATES*			DOCUMENTED HISTORY OF DISEASE*	TITERS*	
					Date	Result
Hepatitis B (for those with potential blood/body fluid contact)	(1)	(2)	(3)		(+)	(-)
Varicella (chickenpox)	(1)	(2)			(+)	(-)
MMR	(1)	(2)			(+)	(-)
Measles (rubeola) (Only 1 dose required if born before 1957)	(1)	(2)			(+)	(-)
Mumps	(1)				(+)	(-)
Rubella	(1)				(+)	(-)
Diphtheria/Tetanus Not required but please document last dose and update if necessary						
Other Vaccines						
not required but please document date if applicable	BCG					

*Must have documentation of appropriate number of immunizations, **or** documented history of disease **or** positive titer.

Tuberculosis: Two TB skin tests within 12 months prior to your start date at LVHHN, and one of which is within 3 months of the start date:

Date #1: ___/___/___ Result (+) (-)
Date #2: ___/___/___ Result (+) (-)

Or if applicable

Date of first positive TB skin test: ___/___/___ INH Therapy Yes No
Chest x-ray within the past 6 months: ___/___/___ Result nl abnl

I hereby certify that _____ is free from communicable diseases in the communicable state. This individual does not possess any health handicap or other physical limitation which would interfere with his or her ability to satisfactorily perform the duties to which assigned within the scope of duties normally performed in the role identified above. I also certify that the immunization/immunity/testing requirements, as listed above, have been fulfilled.

Health Care Provider's Signature _____

Health Care Provider's Name (print) _____

Phone number _____

Date: _____

Medical Student must return this form to: Sherri White, P.O. Box 7107, Suite 601, Allentown, PA 18105-7017

10/29/04

word/forms1/CEDShealthcertification