OFFICE OF GRADUATE MEDICAL EDUCATION
REGISTRATION FOR CLINICAL EXPERIENCE
MEDICAL STUDENTS, RESIDENTS, FELLOWS, PA STUDENTS
ON ROTATION AT REGIONS HOSPITAL

Last Name: ______________________ First Name: ______________ MI: ______

Address: ____

City: ______________________ State: ______________ Zip: ______

Home Ph: ____________ Pager: ______________ Cell: ______________

Social Security #: ________________ NPI# (if applicable)________________

(All student and resident activity is tracked throughout our teaching institutions by the SSN. The SSN is the only unique number on any individual. It distinguishes individuals that have identical names, i.e. Robert A. Smith, etc. The database that tracks all teaching activities of Medicare reimbursement purposes requires the SSN). Please be assured, your social security number is strictly confidential and will not be used for any other purposes.

Email 1: ______________________ Email 2: ______________________

Please check the appropriate category

☐ Affiliated Fellow ☐ Affiliated Resident ☐ Medical Student ☐ PA Student

Current Student/Resident Training

Current Level: ______________________ Academic Year: ______________________

Home Institution: ______________________ Specialty/Program: ______________________

Dates of Program (beginning – end): ______________________________

Assigned Rotation: ______________________________

Dates of Rotation: ______________________________

Medical School Information

Medical School/PA School Attended (include City & State/Country):______________________

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Resident Medical School Graduation Date: ______________________________

Medical/PA Student Anticipated Graduation Date: ______________________________

For Foreign Medical Graduates

ECFMG#:____________ **Certification Date:** ____________ **Letter Only:** ____________

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Revised: 1/30/2008

RECEIPT AND ACKNOWLEDGEMENT FORM

POLICIES:

I acknowledge that I have read, understand, and agree to abide by the:

- Confidentiality of Patient/Member Information Policy – C201
- Sexual Harassment Policy – C303
- Drug-Free Workplace Policy – C704
- Violent crime Control Act Policy – C530

GME ORIENTATION SUMMARY:

I have received the GME Orientation Summary.

CODE OF CONDUCT:

I acknowledge that I have received, understand and will abide by the Regions Hospital's Code of Conduct and Corporate Compliance Program.

ORIENTATION PACKET:

I acknowledge that I have received the Orientation packet.

I CERTIFY TO THE BEST OF MY KNOWLEDGE THAT THE INFORMATION ON THIS FORM IS CORRECT AND THAT I HAVE RECEIVED THE ABOVE POLICIES

____
Printed Name

____
Signature

____
Date

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