

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

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Ph: _____ Pager: _____ Cell: _____

Social Security #: _____

(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: _____

Assigned Rotation: _____

Dates of Rotation: _____

Medical School Information

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

Resident Medical School Graduation Date: _____

Medical/PA Student Anticipated Graduation Date: _____

For Foreign Medical Graduates

ECFMG#: _____ Certification Date: _____ Letter Only: _____

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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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