

# UW Medicine

## SCHOOL OF MEDICINE

Department of Obstetrics & Gynecology  
BB-667 Health Sciences Building, Box 356460  
Seattle, WA 98195-6460 USA  
Phone: (206) 543-3891 / FAX: (206) 543-3915  
[centej@u.washington.edu](mailto:centej@u.washington.edu)  
[www.obgyn.uwmedicine.org](http://www.obgyn.uwmedicine.org)

OBSTETRICS & GYNECOLOGY  
*University of Washington Medical Center*

Dear Student,

We would like to welcome you to your Obstetrics and Gynecology Basic Clerkship. During this six week clerkship you will have the opportunity to apply and increase your knowledge in both clinical and didactic settings. Most faculty members at our sites enjoy teaching, especially on a one-to-one basis. We hope you will take advantage of their expertise by alert and interested, as well as pleasantly assertive.

Your orientation will take place in Rock Springs on the first morning of your rotation at 9:00AM. You should review pelvic anatomy before the orientation, as well as be familiar with the web based Student Course Guide. You will find the Course Guide especially useful because it contains a description of the clerkship, course requirements, and an explanation of the evaluation instruments. The Guide also includes the required topics for course reading. It will be to your benefit to be familiar with all the topics listed, either through experience or through reading.

Details of your rotation schedule will be available to you at the site. You will need your black bag of instruments for clinic.

Please bring with you a copy of your immunization records to be given to:

Kerry Marshall  
Memorial Hospital of Sweetwater County  
1200 College Drive  
Rock Springs, WY 82901  
(307)352-8334  
Fax: (307)352-8502

2008–2009 Dates to Remember

Complete, up-to-date clerkship and schedule information is available online at:  
[www.obgyn.uwmedicine.org/clerkship](http://www.obgyn.uwmedicine.org/clerkship)

Dates to Remember	Time	Activity	Location
1 <sup>st</sup> day of Clerkship	9:00AM	Caldwell Orientation	Daryl Kaan, MD College Women's Health 3000 College Drive #A Rock Springs, WY 82901 (307)362-1861
Last day of Clerkship	8:15AM	Final Written Exam	Rock Spings
		Complete Evaluations	
	5:00PM	Clerkship Officially Ends	

*If you have any questions, either before or during the clerkship, please do not hesitate to call us.*

Vicki Mendiratta, MD  
Clerkship Director  
OB/GYN Division of Education  
[vmendira@u.washington.edu](mailto:vmendira@u.washington.edu)

Jamie Vickerman  
Clerkship Coordinator  
206-543-3891  
[centej@u.washington.edu](mailto:centej@u.washington.edu)

Student  
University of Washington School of Medicine  
Seattle, WA

Dear Student:

Thank you for your interest in a preceptorship at Memorial Hospital of Sweetwater County. Enclosed are the requisite application materials. In order to expedite processing your application for student privileges, ***please complete and return the following items to me as soon as possible:***

1. Application form
2. Documentation of any current BLS or ACLS (etc) certifications
3. Copy of your current curriculum vitae/resume
4. Copy of your most current transcript
5. The University of Washington will need to provide a letter (which may be mailed or faxed directly to me) indicating that:
  - A. You are currently enrolled in Medical School and are in good standing,
  - B. Your rotation is approved for the dates of \_\_\_\_\_ for an OB/GYN rotation.
  - C. You are covered by the school/facility's malpractice insurance.
6. Provide copies of TB, Rubeolla, Rubella, Hep B immunizations and history of chicken pox.
7. Provide evidence of HIPPA training and understanding.

***Upon arrival you will be photographed for a name badge that you will need to wear while you are in the hospital. You will also be provided with a tour and orientation of the hospital.***

If you have any questions, or if we may be of further assistance to you, please do not hesitate to contact me at 307-352-8334, or via email: [twelsh@minershospital.org](mailto:twelsh@minershospital.org). I look forward to hearing from you!

Sincerely,

Tracey Welsh  
Medical Staff Services Manager  
Enclosures

**MEMORIAL HOSPITAL OF SWEETWATER COUNTY  
INFORMATION FOR  
MEDICAL STUDENTS**

You will be staying at the hospital townhouse. The mailing address is 104B College Court, Rock Springs, WY 82901.

Housekeeping doesn't provide daily or weekly cleaning services for the townhouse. However, if there are any maintenance issues – something is broken or doesn't work, please contact Tracey Welsh at 352-8334 or Cindy Nelson at 352-8412, and they will call maintenance and have them address the issue, right away.

The hospital cafeteria will provide up to \$20 per week for meals. Just show your badge to the cashier, and she will keep track of the amount spent. Please note, any un-spent amount won't be carried over to the next week, and once the amount of \$20 is reached in a given week, the student will then be responsible for their own meals until the next week.

If you have any questions or problems, please contact Dr. Kaan at 362-1861 or Tracey Welsh at 352-8334.

Good Luck!

**MEMORIAL HOSPITAL OF SWEETWATER COUNTY**

**APPLICATION FOR APPOINTMENT TO THE  
STUDENT STAFF**

*Rock Springs, Wyoming*

Dates of Preceptorship: \_\_\_\_\_ through \_\_\_\_\_

**CATEGORY:**

Medical Student	Year
Intern	Year
Resident	Year
Physician Assistant Student	Year
Certified Nurse Midwife Student	Year
Other:	

**IDENTIFYING INFORMATION:**

<b>NAME IN FULL:</b>		
Last:	First:	MI:
Other Name Used (if any):		
<b>Residence Address:</b>		
City, State, Zip:	Phone:	
<b>Mailing Address (if different):</b>		
City, State, Zip	Phone:	
Pager:	Cell Phone:	Email:
SS#:	Date of Birth:	Sex:
Place of Birth:	Marital Status:	
Citizenship (if not US, please provide immigration documentation):		
<b>EMERGENCY CONTACT:</b>		
Name & Relationship:		
Address, City, Zip:		
Home/Work Phone #:	Cell Phone #:	
Other contact name and number:		

**SANCTIONED ROTATION:**

University/Facility:
Physician Supervisor at MHSC:

**SURGICAL ASSISTING PRIVILEGES:**

*Check one:*

- I do NOT request surgical assisting privileges.
- I request surgical assistant privileges. ⇒*Note: You must provide proof of surgical training (e.g., attach documentation to this application or have school mail or fax materials to Memorial Hospital of Sweetwater County — fax number is 307-352-8502.*

**UNDERGRADUATE INFORMATION:**

University:	
Major:	Degree:
Graduation Date:	Areas of Special Interest:

**ADVANCED MEDICAL EDUCATION INFORMATION:**

University:	
Graduation Date:	Degree:
Areas of Special Interest:	

**PROFESSIONAL LIABILITY COVERAGE and LICENSURE**

Insurance Carrier:
Through University?
Please provide letter from school stating coverage.
Have you ever been sued for professional malpractice or have judgments or settlements ever been made against you in professional malpractice cases, or are there any pending?
<input type="checkbox"/> Yes <input type="checkbox"/> No    If "Yes", attach a detailed description.
LIST ALL (past and present) MEDICAL CAREER TYPE OF LICENSURE including STATE in which held: Includes MD, DO, nursing, RT, OT, PT, Rad tech, Chiropractor, Acupuncture, etc. etc.
1)
2)
3)

**BACKGROUND INFORMATION:**

Has your license to practice in any jurisdiction ever been refused, challenged, limited, suspended or revoked or have disciplinary proceedings ever been instituted against you?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have your privileges at any hospital or health care facility ever been denied, suspended, diminished, revoked, or has disciplinary action ever been instituted?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you voluntarily withdrawn your application for membership and/or privileges at another hospital or institution?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any medical organization, hospital or medical staff, or have such proceedings ever been initiated against you?	<input type="checkbox"/> YES	<input type="checkbox"/> NO



**abide by the Memorial Hospital of Sweetwater County Code of Behavior, and to follow the policy of MHSC in that all individuals within its facilities be treated courteously, respectfully and with dignity. To that end, while at MHSC, individuals who are granted medical privileges agree to conduct themselves in a professional and cooperative manner. All such individuals shall refrain from disruptive, abusive, rude, hostile, or otherwise inappropriate conduct.**

*I agree to work toward the improvements of care and well-being of both patients and staff of Memorial Hospital of Sweetwater County:*

SIGNATURE OF APPLICANT, Date

**By applying for appointment to the Student Staff, I hereby signify my willingness to appear for interviews regarding my application, authorize the hospital, its Medical Staff and their representatives to consult with administrators and members of Medical Staffs of other hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on my professional competence, character and ethical qualifications. \_\_\_\_\_ (initial)**

**I hereby further consent to the inspection by the hospital, its Medical Staff and its representatives of all records and documents, including medical records of other hospitals, that may be material to an evaluation of my professional qualifications and competence to carry out the clinical privileges requested as well as my moral and ethical qualifications for staff membership. \_\_\_\_\_ (initial)**

**I understand and agree that I, as an applicant for Student Staff membership, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications. I further agree to notify the hospital of any change in status or other pertinent circumstances which occur during the evaluation of my application. \_\_\_\_\_ (initial)**

**I am not aware of any physical or behavioral condition, including any alcohol or drug dependence, that would affect my ability to perform my professional and medical staff duties appropriately. \_\_\_\_\_ (initial)**

**I will not participate in any form of fee-splitting. \_\_\_\_\_ (initial)**

**I have received a copy of the Memorial Hospital of Sweetwater County Student Policy. \_\_\_\_\_ (initial)**

Full and complete signature

Date

Printed Name: