UW Medicine
SCHOOL OF MEDICINE

Department of Obstetrics & Gynecology
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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 your 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 Mashall at Memorial Hospital of Sweetwater

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

Date to Remember	**Time**	**Activity**	**Location**
1st day of Clerkship	9:00 AM	Orientation	College Women's Health 3000 College Drive, #A Rock Springs, WY 82901
Last day of Clerkship	8:15 AM	Final written exam Complete Evaluation	Cheyenne or Seattle
	5:00 PM	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

Whitney Hiatt
Clerkship Coordinator
206-543-3892
whiatt11@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. 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:			
NAME IN FULL:			
Last:	First:		MI:
Other Name Used (if any):			
Residence Address:			
City, State, Zip:		Phone:	
Mailing Address (if different):			
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):			
EMERGENCY CONTACT:			
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 most 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?
❑ Yes ❑ 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?	❑ YES	❑ NO
Have your privileges at any hospital or health care facility ever been denied, suspended, diminished, revoked, or has disciplinary action ever been instituted?	❑ YES	❑ NO
Have you voluntarily withdrawn your application for membership and/or privileges at another hospital or institution?	❑ YES	❑ 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?	❑ YES	❑ NO

Have you ever had malpractice or liability insurance coverage denied, suspended or not renewed?	❑ YES	❑ NO
Do you have a physical or mental condition which could affect your ability to exercise the clinical privileges requested or would require an accommodation in order for you to exercise the privileges requested safely and competently? *If you answer "yes", and are found to be professionally qualified for medical staff appointment and the clinical privileges requested, you will be given an opportunity to meet with the hospital CEO to determine what accommodations are necessary or feasible to allow you to practice safely.*	❑ YES	❑ NO
Have you ever been convicted of or treated for drug/alcohol addiction or dependence?	❑ YES	❑ NO
Have you ever been convicted of a felony?	❑ YES	❑ NO
Have you ever been convicted of a misdemeanor relating to a controlled substance, illegal drugs, insurance fraud or abuse, or violence of any kind?	❑ YES	❑ NO

IF THE ANSWER TO ANY OF THE ABOVE QUESTIONS IS "YES", GIVE FULL DETAILS ON A SEPARATE SHEET, or use this area provided:

PHYSICAL EXAM and HEALTH INFORMATION:

Date of most recent physical examination:

PLEASE PROVIDE DOCUMENTATION OF THE FOLLOWING:

Most recent TB test, Evidence of immunity to Rubella, Rubeola, Hepatitis B and Hx of Chicken Pox.

AGREEMENTS:

I FULLY UNDERSTAND THAT ANY MISSTATEMENTS IN OR OMISSIONS FROM THIS APPLICATION CONSTITUTE CAUSE FOR DENIAL OF APPOINTMENT OR CAUSE FOR SUMMARY DISMISSAL FROM THE PRECEPTEE STAFF. ALL INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE TO MY BEST KNOWLEDGE AND BELIEF.

SIGNATURE OF APPLICANT, Date

CODE OF PROFESSIONAL AND ETHICAL CONDUCT RESOLUTION:

In making this application for appointment to the Student Staff of this hospital, I agree to

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:	