

Application for Clinical Training

SECTION I: to be completed by trainee (please type or print clearly)

Name: _____
Last
First
Middle Initial

Social Security #* (for medical students) _____

Date of Birth _____
Female
Male
Place of Birth (City/Country)
()
()

_____ Email _____
Permanent Telephone
Local Telephone

Permanent Address: _____
Street
City
Zip Code
Country

Local Address: _____
Street
City
Zip Code
Country

_____ Medical School _____
Year in Curriculum
Undergraduate School, Degree and Year

Training Request Type: Visiting Resident Student Clerkship Other: _____

Specialty Area: Fam Med OB/GYN Surgery Ophth Neurology Other: _____

Requested Time Period: _____

Are you planning to apply to a Group Health Residency Program? Yes No Undecided

At the time requested, I will have completed training in the following areas: _____

Areas of medical interests (include specialties): _____

Reasons for interest in Group Health: _____

Expectations of Rotation: _____

***Note: Your social security number is needed to authorize you access to Group Health Intranet Resources and will not be shared outside of the Information Security Department**

For Preceptor Use Only		<input type="checkbox"/> APPROVED	<input type="checkbox"/> DECLINED
Name	Signature	Mailstop	Date

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SECTION II: FOR RESIDENTS, MEDICAL STUDENTS & PHYSICIAN ASSISTANTS ONLY
To be completed by Dean or Authorized official of trainee's institution
(University of WA clerkships may skip this section)

Trainee Name

The above named trainee is in good standing at this institution and is authorized to take this position.

1. This applicant **(has) (has not)** received a PASS grade on **Step I or II or III** of the United States Medical Licensing Examination (if applicable). *(Circle one)*

2. Malpractice/liability insurance **must** cover the trainee away from the degree-granting institution. Coverage limits are: _____; the carrier is: _____. **Coverage is required and will not be provided by Group Health Cooperative.**

3. The trainee has/has not completed a documented program on universal precautions ensuring the appropriate handling of blood, tissues and bodily fluids.
 - Date course completed: _____
 - The trainee **(was) (was not)** tested on the course material.

4. The trainee **(has) (has not)** completed and passed a documented HIPAA training course.

5. A clerkship evaluation **(is) (is not)** required.

6. The trainee has completed the following immunizations (required for participation in hands-on clerkships at Group Health Cooperative):
 - _____ MMR; (Measles, mumps, rubella) 2 positive serologies or 2 doses of vaccine after 1968 (the last given after 1979)

 - _____ Hepatitis B: series of 3 and follow-up titer

 - _____ Tuberculin Test (within last 12 months)

Name and Title of School Official: _____

School: _____

Address: _____

Official's Signature: _____ Date: _____

SECTION III: Trainee Placement Agreement for Individual Clinical Experience (University of WA clerkships may skip this section)

This Agreement confirms your clinical placement at Group Health Cooperative (“GHC”), which will begin on **Date**. Your clinical experience will conclude on **date** unless GHC finds reason in its sole discretion to terminate the placement at an earlier time pursuant to Paragraph 5, below. Work schedules will be mutually determined with the preceptors of the clinical experience. The clinical placement will take place at GHC’s **Specific Site** in **City**, Washington.

The following outlines mutual expectations for clinical placement between a trainee and GHC. This Agreement applies to any individual trainee from an educational institution that does not have a signed affiliation agreement with GHC.

1. You (trainee) agree to obtain and maintain either through your own individual or institutional coverage with professional liability coverage in the amount of at least one million dollars (\$1,000,000) per occurrence and three million dollars (\$3,000,000) in aggregate and deliver a Certificate of such insurance to GHC prior to the placement.
2. You agree to provide verification of current employment, continuing education, and relevant clinical experience at GHC’s request. A criminal background check may be required.
3. **For Residents:** You agree to provide verification of professional licensure and certification from the Drug Enforcement Agency (DEA).
4. You agree to provide verification of health insurance coverage in the event of accident or illness at Group Health. If you do not possess Group Health coverage, you will be responsible for all costs associated with your care conducted at Group Health.
5. You agree to comply with applicable health regulations, which include providing to GHC**:
 - Laboratory evidence of immune status for Rubella and Rubeola. In the absence of laboratory data, documentation of appropriate vaccination is required (Rubella vaccine on or after first birthday and two Rubeola vaccines, two doses after 1968).
 - Laboratory evidence of immune status for Hepatitis B. If laboratory evidence is not available, documentation of the three dose Hepatitis B vaccine series is required. If you wish to decline the vaccine series, you must promptly provide a signed declination form.
 - Evidence of negative Mantoux Tuberculin skin test (PPD) within one calendar year. If you have had a history of a positive Tuberculin skin test, documentation of a negative chest x-ray after the positive PPD is required.
 - Documentation of Bloodborne Pathogen training within the last twelve (12) months for trainees who have contact with potentially infectious materials
6. You agree to maintain the confidentiality of GHC’s proprietary information and to adhere to and comply with all applicable GHC policies including those policies on patient confidentiality, the GHC Patient Bill of Rights, and employee health and infection control.
7. GHC retains the right to withdraw you from any particular assignment or to terminate your entire clinical placement at any time if it deems your performance to be inadequate in any way including but not limited to unacceptable performance based on inappropriate behavior, malpractice, or unethical conduct. Such a determination will be made at GHC’s sole discretion.
8. You agree to identify learning goals and objectives. Demonstration of clinical competency and knowledge will be based on the standards and criteria established as appropriate for the clinical placement, job responsibilities, or standards of practice.
9. You will function under the direct supervision of assigned preceptor(s) at all times. Direct supervision requires observation of all skills and activities by the preceptors.
10. GHC will provide a reasonable orientation to the facility and unit operations.

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11. If you desire to participate in research activities involving GHC patients, employees, records, or data, you agree that you must first receive prior approval from the appropriate GHC department head(s), the GHC Research Committee, and the Human Subjects Review Committee (if human subjects are involved). If you desire to initiate or conduct a research activity of any kind during your clinical education experience, you agree that you will submit a written proposal for prior review and written approval by the above entities. These entities will also resolve whether an activity constitutes scientific research requiring prior review and written approval. Finally, you agree to submit any proposed publication(s) related to your clinical education experience for prior review and written approval by the above entities, as well as by the GHC Communications and Community Relations Department.
 12. The preceptor(s) will complete the final clinical evaluation in conjunction with any documentation or other requirements from your educational institution, **Name of University or School**.
 13. You acknowledge and agree that you shall receive no pay for your voluntary participation in the clinical placement and that you will in no sense be considered an employee or agent of either GHC or GHC's affiliate medical group, Group Health Permanente ("GHP").
 14. You agree to protect, defend, indemnify, and hold harmless GHC, including GHC's officers, employees, and agents, and GHP, including GHP's officers, employees, and agents, from any and all costs, claims, judgments, or awards of damages, including any judgment, award, and cost arising therefrom including attorneys' fees, arising out of or in any way resulting from your negligent acts or omissions in performance of this Agreement. This indemnification shall include recovery of any judgment, cost, attorneys' fee, or damage claimed by third parties.
 15. Paragraph 1 (insurance), Paragraph 4 (proprietary information and patient confidentiality), and Paragraph 12 (indemnification) shall survive termination of this Agreement.
 16. This Agreement may be modified at any time only in writing by the mutual consent of the parties.
 17. The law of Washington State shall apply to this Agreement and to all actions arising out of this Agreement.
- ** GHC must receive a copy of your immunization and vaccination records (or Hepatitis B declination form) for verification by the preceptor within five to seven days of the clinical placement.

Your signature on the letter below indicates that you have read and understand the above requirements of the Agreement. A signed letter must be on file with GHC prior to your beginning the clinical placement.

I have read the Agreement above and understand and agree to all the requirements stated.

Signature of trainee Date

Printed name of trainee

Cc: Preceptor(s) and Manager

RETURN TO:

Jung G Kim
Graduate Medical Education Coordinator
Group Health Cooperative-FMR
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