

Medical Student Information Form

Student Information:

Dates of Student's Rotation: From: _____ To: _____

1. Teaching Attending Physician Name (s):

2. Student's Name: _____

3. Social Security Number: _____ DOB: _____

4. Home Address: _____

5. Cell Phone: _____

6. Email Address: _____

7. Name and phone number of person to contact in case of an emergency:

a. Name: _____ Relationship with Student: _____

b. Phone number: _____

8. Program:

a. Name of Program Institution: _____

b. Name of Education Coordinator: _____

9. Month and Year of Student graduation: _____

Daily Schedule:

Medical Student Information Form

I attest that I have read the KYCOM Clinical Rotations Manual. I further acknowledge that I accept all of the rules and regulations within the text and am bound to follow them as written. I understand that submittal of this attestation form is a requisite to begin the clinical rotation experience.

Student signature: _____ **Date:** _____

Printed Name

MRMC Health Security and Confidentiality Agreement

I have received Meadowview Regional Medical Center's IT Security and Confidentiality Agreement and will abide by the responsibilities:

Student signature: _____ **Date:** _____

Printed Name

HIPAA -PATIENT PRIVACY PROGRAM

I have received Meadowview Regional Medical Center's HIPAA-patient privacy program and will abide by the responsibilities:

Student signature: _____ **Date:** _____

Printed Name

Code of Conduct

I have received Meadowview Regional Medical Center's Code of Conduct and will abide by the responsibilities:

Student signature: _____ **Date:** _____

Printed Name