

## Visiting Medical Students/Residents and Fellows Rotations Check

*Please make sure you have filled out all these required forms and submit to the address below. Thank you.*

<b>CHECKLIST ITEMS</b>	<b>FORM Number</b>
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- |  |                         |
|--|-------------------------|
| <input type="checkbox"/> <b>Application for Medical Student/Residency Rotation Form filled out completely, signed and dated.</b>   | <i>Form c)</i>          |
| <input type="checkbox"/> <b>Application for Medical Student/Residency Rotation filled out completely and signed by Dean or Residency Director</b>  | <i>Form d)</i>          |
| <input type="checkbox"/> <b>Health-Related Documentation Form filled out completely and signed by Student Services/Registrar Representative</b>  | <i>Form e)</i>          |
| <input type="checkbox"/> <b>Clinical Rotation Preceptor Agreement Form and all other documentation has been given to Preceptor and Preceptor has signed and dated Clinical Rotation Preceptor Agreement Form</b> | <i>Form f)</i>          |
| <input type="checkbox"/> <b>Confidentiality Agreement must be signed and submitted to Bayfront Medical Center</b>  | <i>Form g)</i>          |
| <input type="checkbox"/> <b>All ORIGINAL application forms for Medical Student/Residency Rotation have been submitted to the following address</b>   | <i>Forms c) thru g)</i> |

Bayfront Medical Center  
Attention: Medical Education Coordinator  
Family Health Center, 3<sup>rd</sup> Floor  
Medical Education Department  
700 6<sup>th</sup> Street South  
St. Petersburg, FL 33701-4891  
Phone: (727) 893-6959      FAX: (727) 553-7952

**All documentation must be received prior to beginning educational activities at Bayfront Medical Center.**

## Bayfront Medical Center

### PROCESS FOR APPROVING ROTATIONS FOR VISITING MEDICAL STUDENTS, RESIDENTS AND FELLOWS

1. Request for rotation is received from student, preceptor, or institution.
2. Student/Preceptor/Educational Institution are required to provide to the Bayfront Medical Center Department of Medical Education, the following items:
  - A. Completed **Application For Student / Residency Rotation** form
  - B. Specify educational objectives to the intended preceptor.
3. Preceptor is required to:
  - A. Review objective to assure they can be accomplished.
  - B. Assure his/her liability insurer is aware of preceptorship.
  - C. Complete an evaluation within one week of completion of rotation.
  - D. Assure that supervision of the student is available throughout the rotation.
  - E. Return **Preceptor Agreement** form.
4. Medical Education Committee will:
  - A. Review any recurring agreement prior to start of rotation.
  - B. Request reports from Medical Education Department on an ongoing basis of education activities at Bayfront Medical Center.
5. The Medical Education Department will review each applicant's file to ensure all is in order and confirm with student.
  - A. Keep completed application files verifying start date and duration and type of rotation, including proof of the student's status in good standing, professional liability protection and proof of required health tests and immunizations.
  - B. Distribute monthly student rotation schedule to appropriate Bayfront Medical Center departments to track students.
  - C. Forward application packet information to the involved department.
  - D. Request periodic reports from departments involved capability to accept students.

**BAYFRONT MEDICAL CENTER  
CLINICAL ROTATION PRECEPTOR AGREEMENT**

f)

Dear \_\_\_\_\_:

Our office has been informed that you have agreed to function as a clinical preceptor for the student listed below. Please review this information for accuracy, sign indicating your acknowledgment, and return this form to:

**Bayfront Medical Center  
Attention: Medical Education Coordinator  
Department of Medical Education  
700 Sixth Street South  
St. Petersburg, FL 33701  
Phone: (727) 893-6959 Fax: (727) 553-7952**

**Student's Name:** \_\_\_\_\_

**Rotation:** \_\_\_\_\_

**Dates of Rotation:** \_\_\_\_\_

1. I accept responsibility as this student's preceptor.
2. I understand:
  - A. Medical students from LCME/AOA and foreign medical schools, approved by the Florida Commission for Independent Education, may participate in clinical activities. All other medical students may only observe ("shadow") at Bayfront Medical Center facilities.
  - B. All notes and orders written by my student must be co-signed by me (preceptor).
  - C. I am responsible for completing and returning the student's evaluation as directed by the student or institution.
  - D. All procedures performed by my student must be done in the presence of myself, or my designate.
  - E. The Agency for Healthcare Administration guidelines relative to reporting untoward incidents (patient death, brain damage, spinal damage, permanent disfigurement, fracture or dislocation of bones or joints) require that should an incident be deemed reportable, all personnel directly involved in the incident will be reported. This would include student's preceptor.
3. I am aware that I may need to notify my malpractice liability insurer of my participation in this preceptorship.

\_\_\_\_\_  
**Preceptor's Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Preceptor's Print Name**

**\* Responsibility of the student/resident to obtain preceptor's signature.**

**Bayfront Medical Center**  
**Procedures for Enrollment of Off-Campus Allied Health Students,**  
**Medical Students, Residents, and Fellows**

b)

The following procedures are intended to identify and coordinate the various students in training at the hospital.

Definitions:

Allied Health Professional (AHP) students include physician assistants, nurse practitioners, including neonatal, family, geriatric and specialty nurse practitioners and nurse midwives. Medical students are normally students from the Liaison Committee for Medical Education (LCME) or American Osteopathic Association (AOA) accredited medical schools, and foreign medical schools approved by the Florida Commission for Independent Education.. Residents and Fellows are physicians currently enrolled in an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) approved graduate medical education program.

A preceptor's designate is an individual who possesses the same Florida license (i.e., physician, nurse practitioner, physician assistant, etc.) as the designated preceptor.

Information Required From the Student:

The student must return the attached application, available from the Department of Medical Education (727) 893-6959; FAX (727) 553-7952, or medical staff offices, which supplies:

1. The name, address, etc. of the student.
2. The institution from which the student comes and documentation of the student's qualifications.
3. Documentation of health and liability insurance for the student.
4. The dates of rotation and educational objectives.
5. Documentation of required tests or immunizations.

Information Required From the Preceptor:

The preceptor must complete the attached form, which confirms that the preceptor:

1. Accepts responsibility as the student's preceptor:
2. Understands that:
3. Medical students from LCME/AOA accredited medical schools, and foreign medical schools approved by the Florida Commission for Independent Education, may participate in clinical activities. All other medical students may only observe ("shadow") at Bayfront Medical Center facilities.
  - A. All notes and orders written by the student must be co-signed by the preceptor or designate.
  - B. Preceptor is responsible for completing and returning the student's evaluation as directed by the student or institution.
  - C. All procedures performed by the student must be done in the presence of the preceptor or preceptor's designate.
  - D. The Agency for Healthcare Administration guidelines relative to reporting untoward incidents (patient death, brain damage, spinal damage, permanent disfigurement,

- E. fracture or dislocation of bones or joints) require that should an incident be deemed reportable, all personnel directly involved in the incident will be reported. This would include student's preceptor.

A copy of the attached application and supporting documents should be sent to the Medical Education Department for permanent file. A list of all medical students will be reported to the Medical Education Committee monthly and the medical student evaluation on completion will be noted.

The Medical Education Department will review applications for completeness and will periodically request student evaluation of the rotations to determine the success of our teaching effort.

c)

**BAYFRONT MEDICAL CENTER**  
**APPLICATION FOR MEDICAL STUDENT / RESIDENCY ROTATION**

Instructions:

PAGE 1 of 2

1. Complete this form in its entirety.
2. Have a representative of your school or residency complete page 2 of this form.
3. Mail the completed form to:

**Bayfront Medical Center**  
**Attention: Medical Education Coordinator**  
**Family Health Center, 3<sup>rd</sup> Floor**  
**Department of Medical Education**  
**700 Sixth Street South**  
**St. Petersburg, FL 33701**  
**Phone: (727) 893-6959 Fax: (727) 553-7952**

Name: \_\_\_\_\_  
Last First M.I.

Current Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email address: \_\_\_\_\_

**Any Physical Disability Needs?**

Health Insurance coverage is provided by: \_\_\_\_\_

*(Bayfront Medical Center does not provide health liability, or malpractice insurance for visiting students, residents, or fellows ("students"). Students must provide their own health insurance and be responsible for their health care. Malpractice insurance is required, and it is the responsibility of the visiting student to obtain a policy if not covered by the home institution.)*

**NAME OF CURRENT EDUCATIONAL PROGRAM**

*(Medical students from LCME/AOA and foreign medical schools, approved by the Florida Commission for Independent Education, may participate in clinical activities. Other medical students may only observe at Bayfront Medical Center facilities.)*

Medical School \_\_\_\_\_ years of training \_\_\_\_\_

NP/PA Program \_\_\_\_\_ years of training \_\_\_\_\_

Residency \_\_\_\_\_ years of training \_\_\_\_\_

Fellowship \_\_\_\_\_ years of training \_\_\_\_\_

**ROTATION DESIRED**

Family Practice Outpatient \_\_\_\_\_

Acting Medical Intern \_\_\_\_\_

ER \_\_\_\_\_ OB/Gyn \_\_\_\_\_

Other \_\_\_\_\_ Shadow \_\_\_\_\_

**PERIOD DESIRED**

First choice (month/day/year) **From** \_\_\_\_\_ **To** \_\_\_\_\_

Second choice (month/day/year) **From** \_\_\_\_\_ **To** \_\_\_\_\_

Print Preceptor's Name \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**BAYFRONT MEDICAL CENTER**  
**APPLICATION FOR MEDICAL STUDENT / RESIDENCY ROTATION**

d)

**NURSE PRACTITIONER STUDENTS:**

\_\_\_\_\_ Bayfront Medical Center Physician  
 responsible for signing NP protocols for this rotation.

**MEDICAL STUDENTS/RESIDENTS:**

\_\_\_\_\_ Bayfront Medical Center Physician  
 supervising the requested rotation.

I hereby confirm that \_\_\_\_\_ is a student/resident in

good standing at \_\_\_\_\_

*Name of Institution*

I further confirm that the above named student or resident is covered by our institution's malpractice insurance for activities undertaken for curricular-related, credit-bearing reasons. This coverage is either provided by sovereign immunity or provides a minimum coverage of \$1 million per incident and \$3 million aggregate.

\_\_\_\_\_  
*Signature of Dean or Residency Director*

BAYFRONT MEDICAL CENTER

e)

We require the following health-related documentation

- 1. PPD: Affirmation of a PPD skin test within 12 months of visit to Bayfront Medical Center. Documentation of a current chest x-ray for all persons with a history of a positive PPD skin test (within past 12 months).

Positive Negative

IF positive PPD or positive Last CXR:

History of INH From: to

Received BCG? Yes No

- 2. Rubella (German Measles): Affirmation of: 1) a positive rubella immune titer or 2) two immunizations with live rubella vaccine or MMR after 12 months of age

Rubella titer : Positive Negative

OR Live Rubella or

MMR vaccine YES NO

- 3. Rubeola (10-day Measles): Affirmation of: 1) a positive Rubeola immune titer or 2) two immunizations with live Rubeola vaccine or MMR after 12 months of age

Rubeola titer : Positive Negative

OR Live Rubeola or

MMR vaccine YES NO

- 4. Varicella (Chicken Pox): Affirmation of 1) a positive varicella titer or 2) two varicella vaccine immunizations (given 4 to 8 weeks apart). This requirement is only satisfied by having had the titer or 2 vaccine series – having had the Chicken Pox DOES NOT satisfy this requirement.

Varicella titer: Positive Negative

OR Varicella vaccine series: YES NO

- 5. Diphtheria/Tetanus: Affirmation of diphtheria/tetanus booster within last 10 years:

YES NO

- 6. Hepatitis B: Affirmation of: 1) a positive Hepatitis B surface antibody titer, OR 2) a completed Hepatitis B vaccination series.

Surface antibody titer: Positive Negative

OR Vaccine series: YES NO

- 7. Polio: Affirmation of completed polio series.

YES NO

- 8. Standard/Universal Precautions: Personal assurance that you are thoroughly familiar with Standard/Universal Precautions in the management of patients.

YES NO

Signature of Student Services/Registrar Representative

For questions/comments: Medical Education Coordinator (727) 893-6959 Fax: (727) 553-7952

## **SCOPE OF PRACTICE**

*h)*

### **Policy**

Bayfront Medical Center will ensure that each residency program has defined educational activities for each year of training.

Residency program directors will define, and revise as necessary, the range of activities that residents are permitted to engage in.

## **SUPERVISION**

*i)*

### **Policy**

It is the policy of Bayfront Medical Center that postgraduate students (residents and fellows) perform residency related clinical functions only under the supervision of the regular or clinical faculty of the residency.

Supervision may be direct or indirect, as may be directed by the appropriate residency program. Under direct supervision, a resident can perform any procedure or activity for which the attending faculty is physically present and credentialed to perform. For indirect supervision, each residency will establish and maintain a scope of practice statement for each year of residency, indicating activities suitable for performance by residents under indirect supervision.

As stated in the policy on resident appointment, all residents or fellows must possess an active license to practice in the State of Florida, or be registered with the Board of Medicine as an unlicensed physician in training.

## **PROCEDURE**

On a continuing basis, residency directors will ensure that direct supervision is provided to residents by an approved faculty member who is present and credentialed to perform the procedures identified as requiring that level of supervision.

On an annual basis, residency program directors will formulate a scope of practice statement for each year of residency. The scope of practice statement will identify those activities to be performed under indirect supervision, and those residents eligible for that level of supervision.

## CONFIDENTIALITY AGREEMENT

As a team member, visiting medical student or volunteer of Bayfront Health Systems, I understand that I will be working with information that contains patient, team member or financial data. I understand that patient files and medical records are kept to enhance patient care and are the property of the Health System. The information contained within these documents belongs to the patient and the Health System. Patients, team members and medical staff trust me to hold all information in confidence. I will not disclose or remove any information without first seeking guidance from the release of information policies and procedures of the Health System. I understand that both Federal and State laws apply to some incidents of release of information and that violation of department procedures and Health System policies may also be a violation of these laws.

Health System team member information, administrative reports, correspondence and financial data are also considered confidential. It is my responsibility to disclose this information only when directly involved in transacting Health System business. This information may include, but is not limited to, sentinel events or risk management issues, legal issues, team member files, social security numbers, pay rates, disciplinary actions, performance evaluations, financial reports, strategic and marketing plans.

The use of the Health System Information System provides access to highly sensitive information. I agree that my password is the equivalent of my signature and is not to be given to another person. When I am required to change my password, I will do so promptly. I will access only the information which I have been authorized to use, and will not release or discuss any information directly involved in transacting Health System business. I will never attempt to obtain the password of another team member or medical staff member or use their terminal while they are signed on. If I have reason to believe that the confidentiality of my password has been broken, I will contact Information Services immediately.

I will not discuss Health System or patient-related information or business with the news media unless an interview has been prearranged through the Public Relations Department. If I am directly contacted by a representative of the news media (television, radio, newspaper, etc.), I will not answer questions or make comments about any Health System or patient-related information or business. I will refer the media call to the Public Relations Department at (727) 893-6720.

I have read the above statements and accept the responsibility of abiding by the confidentiality policies and procedures of the Health System. I understand that if at any time I violate these guidelines, I am subject to disciplinary action up to and including termination of employment and/or legal action.

My signature is an acknowledgement of any commitment to adhere to these policies. I am aware that this signed statement will become a permanent part of my team member file.

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Team Member / Applicant Signature

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Date