## SINAI HOSPITAL REGISTRATION FORM MEDICAL STUDENTS

## Part I: To be completed by applicant.

Applicant's Name:	Title (MD, DO, DPM):
Rotation Requested:	
Request Dates of Rotation - From:	To:
Alternate Dates of Rotation - From:	To:
E-mail Address:	Date of Birth:
Cell Phone #: Cell F	Phone Provider:
Social Security #:	Pager:
Have you been here before?	_
Resident PA Student PA Student	NP Student
Fellow Clinical or Research (Circle One)	Core/Clerkship Observer
Home Institution (i.e., Hopkins, Univ. of Maryland)	
Licensure for residents and fellows only:  Limited License # (DPM): Unlicensed Mo	edical Practitioner (UMP)#:
If you are new or there are any changes of information, please comp	plete this section.
Medical School:	
Year Grad.: ECFMG	Cert. Date:
Home Address:	
Person to contact in case of emergency:	
Name: Phone:	
Applicant Signature	Date
For Office Use Only: PAS #: Vehicle Hang	Tag #:
WLSHRTPASUMP/LL	Pager # Badge
WLS HRI PAS UNIP/LL	rager # bauge

## Part II: To be completed by home institution. Applicant's Name: The above named applicant is requesting a rotation at Sinai Hospital. Because of the numerous requests for rotations and the necessity to retain adequate records, the following information is requested: - Completed Registration Form - Letter of Good Standing from the Medical School - Verification of Professional Liability Insurance - Verification of Personal Health Insurance - Verification of applicant having received HIPAA/ HITECH Act and OSHA Training - Verification of Immunization and laboratory titers - Verification of a negative PPD or follow-up chest x-ray - Verification of a flu vaccine for the current academic year - Verification of a clear criminal background check and a negative drug screen - Current CV - USMLE/COMLEX Scores - Official Medical School Transcript sent directly to our Medical Education Office - Copies of evaluations (optional) SIGNATURE OF SENDING PROGRAM'S CLINICAL DIRECTOR and INSTITUTIONAL SEAL Fax a copy **AND** return original to: Sinai Hospital of Baltimore **Medical Education Office** 2401 W. Belvedere Avenue Room #C-104 Baltimore, MD 21215 Phone: 410-601-9720 Fax: 410-601-6308 Office use only: Rotation is $\square$ APPROVED (or) $\square$ DENIED Chief or Program Director: **Date:** \_\_\_\_\_ Preceptor's Name: Director Medical Education: **Date:** \_\_\_\_\_ Credentialed By: \_\_\_\_\_ Date: \_\_\_\_\_ For Office Use Only: PAS #: \_\_\_\_ Vehicle Hang Tag #: \_\_\_\_

\_\_\_\_\_ WLS \_\_\_\_\_ HRT \_\_\_\_\_ PAS \_\_\_\_ UMP/LL \_\_\_\_\_\_ Pager # \_\_\_\_ Badge