Medical Student Rotation Application

The Medical Student Rotation Program teaches students essential clinical and practical skills. Participating students rotate with Southampton Hospital faculty and residents in a variety of specialties areas.

Application Process

Clinical rotations are available to students in their final year of medical school. A completed application must be sent to the Jenna Frost. Please indicate on the application the preferred rotation and dates available. Our rotations are four (4) weeks in length. Applications for less than four (4) weeks will not be considered.

All required documents must be sent to the Jenna Frost, by electronic mail, fax or mail. (Electronic Mail Preferred)

Send PDF application and supporting documentation to:
Department of Medical Education
Southampton Hospital
Attn: Jenna Frost
240 Meeting House Lane
Southampton, NY 11968
631-726-0396 (fax)
jfrost@southamptonhospital.org

Medical Education Department (631-726-0409)

- Shawn P. Cannon, DO, FACOI
  Director of Medical Education
  scannon@rpsom.org

- Jenna Frost
  Student Coordinator, Graduate Medical Education
  jfrost@southamptonhospital.org
  631-726-0409 x103

- Karen Roberts
  Manager, Graduate Medical Education
  kroberts@southamptonhospital.org

Rotation Requirements

The following is required in order to process your application. You do not have to send Health documents until you have been granted a spot. After you are granted a spot you will then need to send all necessary health documents to Jenna Frost. Once she receives everything and all health documents are in good standing you will then be confirmed.

Prerequisites

All prerequisites must be met before you are approved for a rotation. This includes the completion of all core rotations and status as a final year medical student when you are scheduled to participate in the rotation.

Certificate of Malpractice Insurance

Most medical schools will provide a certificate of insurance. If your school does not provide malpractice insurance for you on “away” rotations, be sure to provide proof of insurance. You will not be approved without documentation that you have malpractice insurance coverage for your rotation.

Health Requirements

The Office of Medical Education requires medical students to provide proof of the following immunizations:

- Proof of Varicella Rubella, Rubella immunity (serology)
- Proof of Hepatitis B immunity (serology)
- Recent documented PPD (< six month) test or recent chest x-ray (< 1 year) if known PPD positive
- Proof of bloodborne pathogen training or training will be provided prior to starting rotation
- Proof of Flu Vaccine – During flu season, evidence of vaccination must be presented
All students must provide health documentation in order to begin a scheduled rotation.

**Health Insurance**
Proof of health insurance must be provided before the student can start his/her rotation. Southampton Hospital does not provide health insurance to students.

**Letter of Good Standing**
Please have your school forward a letter of good academic standing and approval of the rotation for credit. An evaluation of your performance on the rotation will be forwarded to your school upon completion of the rotation.

**Cancellation Policy**
Once your assignment has been confirmed, either by phone and/or mail, you are expected to complete the rotation. While cancellation may be necessary, please do so at least 90 days in advance.

**Housing**
Subsidized housing is available on a first-come, first-served basis. In the event Southampton Hospital cannot provide housing, students are responsible for their own accommodation arrangements.

**Meals**
Meals are at a subsidized rate upon presentation of Southampton Hospital Medical Student ID.

**Parking**
Parking is provided at no charge. Students must park in the Employee Parking Lot or in the Annex Parking Lot. Visitor and Emergency Parking Lots are off limits.

**White Coats**
Be sure to bring your white coat; it is required that you wear one while on the premises of Southampton Hospital or any off-site clinics.

**Miscellaneous**
Students are expected to bring their own diagnostic equipment and textbooks.

**Sub-Internship Rotations**
Requests for Sub-Internship showcase rotations should be made during the months of July through December. All other elective Sub-I rotation requests should be made after the December timeframe.

If you are interested in applying to one of the Southampton Hospital Residency Programs, the following Sub-I rotations are available:
- Family Medicine
- Integrated Family Medicine & NMM
- General Surgery
- Internal Medicine

**Sub-Internship Rotation Blocks**
- 07/03/17 -- 07/30/17
- 07/31/17 -- 08/27/17
- 08/28/17 -- 09/24/17
- 09/25/17 -- 10/22/17
- 10/23/17 -- 11/19/17
- 11/20/17 -- 12/17/17

**Elective Rotation Blocks**
- 12/18/17 -- 01/14/18
- 01/15/18 -- 02/11/18
- 02/12/18 -- 03/11/18
- 03/12/18 -- 04/08/18
- 04/09/18 -- 05/06/18
- 05/07/18 -- 06/03/18
Medical Student Rotation Application

Name ________________________________ Gender: □ Female □ Male

Address ____________________________________________

City ___________________________ State __________ Zip ________

Home Phone ___________________________ Cell Phone ________________________ Cell Carrier _______________

Email Address (preferred) ____________________________________________

Emergency Contact Name ___________________________ Phone ________________________

Rotation Selection

Please select a rotation and choice of date in order of preference (1, 2, 3)

Note: Applications for less than four (4) weeks will not be considered. Rotations are available based on first-come first-served basis.

<table>
<thead>
<tr>
<th>Family Medicine SI</th>
<th>FM/NMM SI</th>
<th>Internal Medicine SI</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 07/03/17 -- 07/30/17</td>
<td>4. 09/25/17 -- 10/22/17</td>
<td>6. 11/20/17 -- 12/17/17</td>
</tr>
<tr>
<td>2. 07/31/16 -- 08/27/17</td>
<td>5. 10/23/17 -- 11/19/17</td>
<td></td>
</tr>
<tr>
<td>3. 08/28/17 -- 09/24/17</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Rotation (Choice 1): _______________ Start Date: Choice 1 ______ Choice 2 ______ Choice 3 ______

Rotation (Choice 2): _______________ Start Date: Choice 1 ______ Choice 2 ______ Choice 3 ______

<table>
<thead>
<tr>
<th>Family Medicine Elective</th>
<th>FM/NMM Elective</th>
<th>Internal Medicine Elective</th>
<th>Surgery Elective</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 12/18/17 -- 01/14/18</td>
<td>4. 03/12/18 -- 04/08/18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. 01/15/17 -- 02/11/18</td>
<td>5. 04/09/18 -- 05/06/18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. 02/12/18 -- 03/11/18</td>
<td>6. 05/07/17 -- 06/03/18</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Housing/Transportation

Housing is offered at a subsidized rate. Will you be requiring housing? □ Yes □ No
Transportation is required for housing and rotation options.

School/Rotation Information

School
_________________________________________________________________________________________

Address
_________________________________________________________________________________________

City ___________________________ State ____________________ Zip

School Placement Coordinator ____________________________________

Phone_________________________ Email Address ____________________

Current Year in School: ___________________________ Anticipated Graduation Date ___________________________

Planned Specialty ____________________________________

Have you chosen to focus on primary care in your training? □ Yes □ No
Will you be receiving academic credit for your rotation? □ Yes □ No

Do you have any special circumstances or health concerns, which would influence your housing placement?
Please list: ____________________________________

_________________________________________________________________________________________

How did you hear about our program?

□ College / University Referral (Please specify) ____________________________________

□ Friend / Colleague/Word of Mouth ____________________________________

□ Internet (Please specify website) ____________________________________

□ Other (Please specify) ____________________________________

I certify that the above information is correct to the best of my knowledge at the date of this application. I also understand that completing this application does not guarantee an offer of placement by Southampton Hospital.

_________________________ ________________________
Signature of Applicant Date

Sanford Hospital shall admit students of any race, color, religion, sex, age, national origins or ancestry, handicap, or status as a disabled or Vietnam veteran, to all rights, privileges, programs and activities generally accorded or made available to all of the students involved in any of the hospital’s educational programs.

Sanford Hospital will not discriminate on the basis of race, color, religion, sex, age, nation origins or ancestry, handicap, or status as a disabled or military veteran, in the administration of its educational policies, admissions policies, training programs, stipend awards and all other such administrated programs.