Hope Medical Institute

HOPE CENTER

Clinical Rotation Department
11835 Rock Landing Drive
Newport News, VA 23606
(757) 873-3333 *(Phone)*
(757) 873-6661 *(Fax)*

Attach one passport size photo *(with your name written on the back)* here with a paper clip or glue.
(Please do not staple)

APPLICATION FORM FOR CLINICAL CLERKSHIPS / ROTATIONS IN THE USA OR CANADA

The following information needs to be completed in its entirety for approval of clinical clerkship/rotation in the USA or Canada.

Please type or print legibly
(If you are printing, you are required to use a black or blue ink pen)

_____
First Name *Middle Initial* *Last Name*

_____
Correspondence Address (Street Address or P.O. Box)

_____
City *State* *Zip Code*

_____
Home Phone *Cell Phone (Required)* *E-mail address most frequently used*

_____
Date of Birth (mm/dd/yyyy) *Social Security or Social Insurance #* *Gender*

_____
Full name of emergency contact *Relationship* *Home Number* *Cell Number* *Office Number*

_____
Full name of emergency contact *Relationship* *Home Number* *Cell Number* *Office Number*

_____
Name of Health Insurance Provider / Company *Policy Number* *Effective Date*

I am a student of the Medical University of *(please circle)*: Lublin / Silesia in the 1st / 2nd / 3rd / 4th year of the 6 year program

You must provide us with two references: *(Preferably physicians)*

1. _____
Full name *Contact number* *Years known*

2. _____
Full name *Contact number* *Years known*

I *(print your full name)*, _____, acknowledge that this information is true and accurate. If The Medical Universities of Lublin/Silesia and Hope Medical Institute are unable to verify any of the information listed above, I understand that I may lose eligibility to complete my clinical rotations in the USA and/or Canada.

_____ _____
Student Signature *Today's Date*

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STATEMENT ACKNOWLEDGEMENTS

Please type or print legibly

I *(print your full name)*, _____, a student from The Medical University of *(please circle one)*

Lublin / Silesia, acknowledge and agree to abide by the content listed in the following statements:

Statement of Continuous Clinical Rotation Training in the USA or CANADA:

⇒ I understand and acknowledge that The Medical Universities of Lublin/Silesia and Hope Medical Institute do not guarantee continuous rotations, regardless of my status. Rotations are scheduled based on availability. I also understand and acknowledge that clinical training in the USA or Canada is a privilege, not a right and also that The Medical Universities of Lublin/Silesia and Hope Medical Institute gives no guarantee to me or any other student for doing their clinical training in the USA or Canada. **I understand and acknowledge that I am required to abide by all rules and policies set forth by The Medical Universities of Lublin/Silesia, Hope Medical Institute and its affiliated facilities for clinical training.** I understand and acknowledge that if rotations in the USA or Canada no longer become available to me or not available to The Medical Universities of Lublin and Silesia, I will be required to complete my clinical training in Poland.

Statement of Change / Cancellation of Clerkship/Rotation:

⇒ I understand and acknowledge that once I am scheduled for a clerkship/rotation, I will give a forty-five (45) day notice of any change/cancellation in writing to the HMI Clinical Coordinator. Furthermore, I understand that if I fail to provide proper notice of any change/cancellation, that I may be responsible for full payment of all weekly fees for the changed/cancelled rotation and that my future clerkship/rotation privileges in the USA or Canada may be suspended or possibly revoked. In addition, I will be responsible to pay a **$350.00 cancellation fee in advance of cancelling the rotation.**

Statement of Suitability of Clerkship/Rotation:

⇒ The criteria by which a state recognizes the clerkship/rotation training of those who apply for residency and/or for licensure as a physician, varies in complexity and content from state to state and can be changed periodically. It is the student's responsibility to verify that the credit received for rotations obtained through this program will be acceptable to the state in which the student wishes to do residency and/or practice in. All students are encouraged to familiarize themselves with the regulations governing residency and physician licensure in the state(s) in which they wish to do residency and/or practice in and to make the determination whether the rotations meet the criteria. Hope Medical Institute and its affiliated medical universities assume no liability and do not make any guarantees or promises with regard to the suitability of clerkships/rotations for the purpose of residency and/or physician licensure in any state as state rules change periodically. Please check with any specific state medical licensing board/authorities periodically for further residency/licensure requirements or you can also check through the Federation of State Medical Boards website (**http://www.fsmb.org/**).

_____ _____

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FEES FOR CLINICAL CLERKSHIP/ROTATION TRAINING IN THE USA OR CANADA

Please type or print legibly

I *(print your full name)*, _____, a student from The Medical University of *(please circle one)* Lublin / Silesia, acknowledge and agree to abide by the content listed in the following statements:

⇒ As part of the application process, I agree to pay a **One-time Clinical Administrative Fee of $1,000.00** *(Non-refundable when the clinical schedule is issued)* and a National Criminal Background check fee of **$60.00** along with the application form *(As described on page 8 of this application)*. I agree to pay The Medical Universities of Lublin/Silesia and Hope Medical Institute for my clerkship/rotation training in the USA for administrative and educational/tuition related fees of **$1025.00** *(One Thousand Twenty Five US Dollars)* **per week** for the intended training in the USA. Rates for rotations in Canada will be calculated at the time of request, if available. These fees are applicable regardless of where I attend clinical training ***(whether it is arranged by Hope Medical Institute at the university affiliated hospitals or by my own efforts at a non-affiliated hospital)***. I understand that these fees are charged for every rotation that I train for. All fees are subject to change upon written notification by The Medical Universities of Lublin/Silesia and Hope Medical Institute and are non-refundable. Additional background checks may be required annually at a cost of $60.

⇒ **Professional liability/malpractice insurance will be provided through Hope Medical Institute** and I understand and agree that I am required to pay a fee of **$25.00 per week.** Once I am added to the policy, I acknowledge that I **cannot** be removed until I have completed all of my clinical rotations. **I also understand, acknowledge and agree that if I take time off, for whatever reason, I am still required to pay the weekly malpractice charge even while not in rotations.**

⇒ I agree to keep my payments current at all times. However, if I have any unforeseen circumstance that occurs and know that it will affect my account, I will immediately inform both the clinical and accounting departments to see what options are available to me.

⇒ I agree that I will pay a **$350.00** cancellation fee in advance if I fail to provide appropriate notice for a cancellation / change in my schedule as listed on Page 2 of this clinical application.

⇒ I understand that, regardless of my financial aid activity *(based on availability and student eligibility)* or status, I can be cancelled, blocked or stopped from rotating and /or further scheduling in the USA or Canada if my account is not in good standing.

⇒ I agree to pay The Medical Universities of Lublin/Silesia and Hope Medical Institute a **$550.00** diploma processing fee upon completion of all my medical school requirements.

⇒ I hereby acknowledge that I must contact Hope Medical Institute to receive approval for my clerkships/rotations, submit all required documents, and pay all required fees in order to receive credit for my clerkship/rotation training in the USA or Canada. In addition to the above, I also understand that The Medical Universities of Lublin/Silesia and Hope Medical Institute reserves the right to make minor changes in policies and procedures or fee increases from year to year upon written notice.

_____ _____

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FACILITIES FOR CLINICAL CLERKSHIP/ROTATION TRAINING IN THE USA OR CANADA

Please type or print legibly

I *(print your full name)*, _____, understand that The Medical Universities of Lublin/Silesia and Hope Medical Institute have several affiliated facilities available for clinical rotations. I fully understand that The Medical Universities of Lublin/Silesia and Hope Medical Institute do not give any guarantee to any specific location of clinical training, and that I will be scheduled according to what is available.

Important Notes:

⇒ I agree and understand that I will be placed in the affiliated hospitals that The Medical Universities of Lublin/Silesia and Hope Medical Institute have available for clerkship/rotation training in the USA or Canada.

⇒ The clinical rotations will be scheduled as per date and space availability. I fully understand that The Medical Universities of Lublin/Silesia and Hope Medical Institute does not recommend me to sign a long term lease in any city or state, as schedules are also subject to change at any given moment. I will also contact the clinical department to confirm my schedule from time to time to verify where I am scheduled at.

⇒ I understand and acknowledge that I am not permitted to contact any hospital facility, administrator, or physician to schedule/reschedule and/or to complete rotations without prior approval/authorization from The Medical Universities of Lublin/Silesia and Hope Medical Institute. I also understand and acknowledge that if any rotations are completed without prior approval/authorization from The Medical Universities of Lublin/Silesia and Hope Medical Institute, I may possibly lose credit, be financially responsible for payment and have to repeat the un-authorized rotation.

⇒ I know that in order to start clerkships at any of our New York locations, I will be required to complete an application for a long-term clerkship. **I acknowledge that this can only be done when I get an E-mailed schedule from the clinical department with detailed instructions on how to complete the application.**

⇒ I understand that I am **only** allowed to attend a **maximum of eight (8) weeks** of clinical clerkships/rotations **at a non-affiliated hospital.** The rotation(s) that I attend must follow to what is listed in the required curriculum and cannot be a core rotation. Non-affiliated rotations are to be arranged by the student directly with the institution. Please refer to the Clinical Packet for additional instructions.

- In order to attend, I must complete the "Request for doing Elective Clerkships at Non-Affiliated Teaching Hospitals" and submit the original signed copy to Hope Medical Institute. I acknowledge that I may attend this rotation **only after receiving a <u>confirmation of approval</u>** from both The Medical Universities of Lublin/Silesia and Hope Medical Institute.

⇒ I understand and acknowledge that The Medical Universities of Lublin/Silesia and Hope Medical Institute have not made me or any other student a guarantee regarding length of stay at any facility and that <u>I have been asked not to sign a long term lease anywhere.</u>

_____ _____

Student Signature *Today's Date*

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HEALTH ASSESSMENT FORM

Please type or print legibly

Hope Medical Institute and its affiliated hospitals require a recorded medical history, physical examination and titer verification *(for Measles, Mumps, Rubella, Varicella and Hepatitis B)* for all prospective clerkship/rotation students. Clerkships/rotations cannot begin until the following assessment is completed by a licensed physician. If results do not demonstrate immunity, you must attach proof of a booster. Any negative titer must be re-titered after one month after the vaccination and proof of those lab results must be submitted.

_____

First Name *Middle Initial* *Last Name*

_____

Date of Birth (mm/dd/yyyy) *Social Security/Insurance #*

Medical History

Past History: _____
_____
Recent Illness *(Detail)*:_____
_____
Allergies:_____
Current Medications *(Detail)*:_____

Physical Examination

BP:_____ Pulse:_____ Temp:_____ Weight:_____
HEENT:_____
LUNGS:_____
HEART:_____
ABDOMEN:_____
EXTREMITIES:_____
NEURO:_____
OTHER:_____

Antibody Titers / TB Status

All supporting laboratory work *(Titers, CXR, Booster(s), etc)* must be submitted with this form!

Test	**Date**	**Immune Status** *(Circle One)*		**If Negative, Date of Booster**
Measles	_____	+	-	_____
Rubella	_____	+	-	_____
Mumps	_____	+	-	_____
Varicella	_____	+	-	_____
Hep B Antibody	_____	+	-	(1)_____ (2)_____ (3)_____

PPD _____ CM _____ Date: _____ If positive: CXR:_____ BCG? _____ UA Micro _____
PPD _____ CM _____ Date: _____ *(If negative, repeat within 1 month of exam date)*

Examining Physician's Statement

I have determined that the above named person is free from any health impairment which is of potential risk to patients or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol, or other drugs or "substances" which may alter the individual's behavior.

Examining Physician's Name:_____ Examining Physicians License #:_____
Examining Physicians Signature:_____ Date of Examination:_____

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ACKNOWLEDGEMENT OF PROFESSIONAL CONDUCT AND BEHAVIORAL STATEMENT

The Medical Universities of Lublin/Silesia and Hope Medical Institute expect all students to comply with the strict guidelines of professional conduct and appropriate behavior within affiliated **and** non-affiliated facilities while in clinical clerkships/rotations.

The Medical Universities of Lublin/Silesia and Hope Medical Institute have developed relationships and agreements with affiliated and non-affiliated hospitals, which expressively state that all students will present themselves in the most professional manner and conduct themselves in accordance with our agreements and standards set by the hospital(s). Students are required to follow all instructions from their Coordinators and all paperwork must be submitted as required by hospital officials.

Improper behavior and unprofessional conduct may result in disturbance up to expulsion from the clinical program in the USA and Canada. The following are strictly prohibited:

- ⇒ Excessive tardiness and/or not showing up to clinical clerkships/rotations and/or rounds, lectures and anything additional required by your attending or the hospital.
- ⇒ Improper hygiene habits. This means you must be properly groomed and professional looking at all times.
- ⇒ Failure to dress in a professional manner for your clinical rotations. **Please make sure that you wear a clean, pressed short white lab coat for your clinical rotations, unless specifically noted otherwise.**
- ⇒ Inappropriate communication and/or behavior with patients, staff members, preceptors or coordinators.
- ⇒ Falling asleep during your clinical clerkships/rotations.
- ⇒ Removing any instruments and/or materials without prior authorization.
- ⇒ Harassing any hospital personnel for any reason. *(All inquires scheduling/rescheduling, changes in schedule and questions regarding your clinical clerkships/rotations must be made to the HMI clinical department **ONLY**.)* **Violation of such guidelines may be grounds for losing your clinical training privileges in the USA or Canada.**
- ⇒ Disclosing confidential information regarding the hospital, training site and/or physician, and/or patient's private or health related information to any unauthorized personnel.
- ⇒ Participating in any substance abuse activities.
- ⇒ Disrespecting any university, HMI or hospital personnel, for any reason.

This statement is not limited to that which is listed thereof. **Any** deemed unprofessional conduct and/or improper behavior will be subject to the consequences outlined in this statement.

I have read the above statement and acknowledge the guidelines of The Medical Universities of Lublin/Silesia and Hope Medical Institute in regard to unprofessional conduct and improper behavior. I further attest that I understand that any such violation may result in being interrupted up to expelled from continuing clinical clerkships/rotations in the USA and Canada.

Student Printed Name	*Student Signature*	*Today's Date*

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CLINICAL CLERKSHIPS/ROTATIONS REQUEST FORM

Please type or print legibly

To: Hope Medical Institute, Clinical Department ***and***
The Medical University of *(please circle one)*: Lublin / Silesia / Other _____, Dean's Office

I *(print your full name)*, _____, request to attend my clinical clerkships/rotations in *(desired country)* _____, beginning *(month and year)* _____.

My USMLE information is as follows:

(Please complete what is applicable in your case in order to be considered for clinical rotations in the USA or Canada)

I *(please circle one)*, have made / am making my attempt at Step I on *(date)* _____

I have received my Step I score and it is as follows *(PDF of score sheet must be sent)*: Score: _____

Please consider my request to begin my clinical rotations in the desired country which I have listed above. **I hereby certify that I have no unsettled accounts with either The Medical Universities of Lublin/Silesia and Hope Medical Institute.**

Sincerely,

_____ _____
Student Signature *Today's Date*

_____
Correspondence Address (Street Address or P.O. Box) *City* *State* *Zip Code*

_____
Home Phone *Cell Phone* *E-mail address for contact*

For Office Use Only:

Account Verifications: _____ *(Univ Balance Due, Date)* _____ *(HMI Balance Due, Date)*

Approvals: _____ *(Signed by Univ. Dean's Office with date of approval)*

_____ *(Signed by HMI Clinical Dept with date of approval)*

DISCLOSURE AND AUTHORIZATION FOR CONSUMER AND/OR INVESTIGATIVE CONSUMER REPORT

Company Name: Hope Medical Institute

In connection with your application and/or employment with above listed Company (hereinafter "the Company") this notice is provided to inform you that a "consumer report" and/or "investigative consumer report," as defined by the Fair Credit Reporting Act (15 U.S.C. § 1681), may be obtained from a consumer reporting agency for employment purposes. These reports may include information about your character, general reputation, personal characteristics and mode of living, whichever are applicable. The report may also contain information about you relating to criminal history, credit history, motor vehicle records such as driving records, workers' compensation claims (post job offer or conditional job offer), verification of education or employment history, social media or other background checks. They may involve personal interviews with sources such as your neighbors, friends or associates. You have the right, upon written request made within a reasonable time after receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report to the Company and National Crime Search, Inc., 3452 E. Joyce Blvd., Fayetteville, AR 72703 – 888-527-3282. For information about National Crime Search, Inc.'s privacy practices see www.nationalcrimesearch.com. The scope of this notice and authorization is not limited to the present and, if you are hired, will continue and allow the Company to conduct future background screenings for retention, promotion or reassignment, unless revoked by you in writing.* The Company also reserves the right to share your report with any third-party for whom you will be placed to work with as a representative of the Company.

Acknowledgement and Authorization

You hereby authorize the obtaining of a consumer report and/or investigative consumer report (criminal background check) at any time after receipt of this authorization by the Company, and if you are hired, throughout your employment, as permitted by law. You also confirm your understanding and provide consent for this report to be shared with a third-party for whom you may be placed to work as a representative of the Company, if applicable.

Signature	Today's Date
Full Legal Name (please print)	Other or Former Names (please print)
Address	City/State
County / Zip	Date of Birth** / SSN
Name on Driver's License (if different from legal name)	Driver's License # / State issued
Contact Phone Number	E-mail address

***To perform a GA Statewide search, the GCIC requires the applicant to have signed the authorization form within the last 30 days.**

****This information will be used for background screening purposes only and no other purpose.**