MOUNTAINS COMMUNITY HOSPITAL
The Heart of Mountain Healthcare

APPLICATION FOR NURSE PRACTITIONER STUDENT ROTATION

PLEASE REMIT

1) Current Government Issued Identification or CA Drivers license
2) School Affiliation Agreement signed by MCH & School
3) Copy of School's Certificate of Insurance for student

1. Identifying Information

Name _____
(Print) FIRST MIDDLE LAST

Birth Date: _____ Birthplace _____ Citizenship: _____

Home Address _____

City, State, Zip _____

Home Phone: _____ Cell # _____

EMAIL Address: _____

MCH Physician Affiliation Name: _____

2. School Information

Name of School Attending: _____

School Address**:** _____
Address City State Zip

Training Program: _____

Current Level of Degree: _____

Expected date of Graduation: _____

3. Disciplinary Actions

If answer to any of the following is "Yes," please give details on a separate sheet. "Yes" responses are not an automatic disqualification.

A. Have you ever received treatment for alcoholism or drug abuse? ___ YES ___ NO
B. Have you ever been convicted of a misdemeanor or felony? ___ YES ___ NO

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CONDITIONS OF APPLICATION

All information submitted by me in this application is true to my best knowledge and belief.

By filing this application for Medical/Nurse Practitioner Student rotation, I acknowledge that I have agree to be bound by the Bylaws of the Medical Staff, Rules and Regulations specific for Medical Students and that I am familiar with the principles of medical ethics of my school association. I agree to be bound by the terms thereof without regard to whether or not I am granted approval of all matters relating to the consideration of my application for a Medical/Nurse Practitioner Student Rotation. I acknowledge my obligation to provide continuous care and supervision of my Supervising Physicians patients.

By requesting affiliation to Mountains Community Hospital, I hereby signify my willingness to appear for any interviews in regard to my application, authorize Mountains Community Hospital, its medical staff and their representatives, to consult with administrators and members of my school faculty or other hospitals or institutions with which I have been associated and with others, who may have information bearing on my professional competence, health status, character and ethical qualifications. I hereby further consent to the inspection by Mountains Community Hospital, its medical staff and its representatives of all records and documents, including medical records, at other hospitals, that may be material to an evaluation of my professional qualifications and competence to carry out my request for Nurse Practitioner Student rotation, as well as, my moral and ethical qualifications. I hereby release from liability all representatives of Mountains Community Hospital and its medical staff, for their acts performed in good faith and without malice in connection with evaluating my application and my qualifications. I hereby release from liability any and all individuals and organizations that provide information to Mountains Community Hospital or its medical staff and their representatives, in good faith and without malice concerning my professional competence, ethics, character and other qualifications, and I hereby consent to the release of such information.

I hereby further authorize and consent to the release of information by Mountains Community Hospital, its Medical Staff and their representatives to other hospitals, medical associations and other interested persons on request regarding any information Mountains Community Hospital may have concerning my professional competence, character, and ethical qualifications as long as such release of information is done in good faith and without malice, and I hereby release from liability Mountains Community Hospital and its staff for so doing.

I understand and agree that I, as an applicant for a rotation as a Nurse Practitioner Student, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.

I have not requested any procedures for which I am not qualified to perform.

DATE _____

SIGNATURE OF APPLICANT _____

PRINT NAME _____

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(This form must be completed by Supervising Physician along with application)

NURSE PRACTITIONER STUDENT PROCEDURES

_____ may perform the following procedures under my supervision:
(Print Student's Name)

With Direct Supervision (*Overseen in the Immediate Area*)

_____
_____
_____
_____

With Remote Supervision (After demonstrating his/her competence, the Nurse Practitioner Student can perform the following procedures without a physician in the room, but must first discuss them with a physician before the procedure(s) is undertaken.)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

_____ _____
Supervising Physician Date

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NURSE PRACTITIONER STUDENT ROTATION ASSIGNMENT

STUDENT NAME:_____
PRINT FULL NAME

TRAINING PROGRAM:_____

SUPERVISING PHYSICIAN: _____

DATES OF SERVICE:_____ TO_____

ACKNOWLEDGMENT:
I have read and understood the attached Mountains Community Hospital Medical Student Practice Protocol and agree to abide by the scope of practice therein.

_____ _____
Nurse Practitioner Student Date

_____ _____
Supervising Attending Physician Date

APPROVED BY:

_____ _____
Chief of Staff Date

_____ _____
Administration Date