

**OFFICE OF GRADUATE MEDICAL EDUCATION  
REGISTRATION FOR CLINICAL EXPERIENCE  
MEDICAL STUDENT/RESIDENTS/FELLOWS/PA STUDENTS  
ON ROTATION AT REGIONS HOSPITAL**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Ph: \_\_\_\_\_ Pager: \_\_\_\_\_ Cell: \_\_\_\_\_

Social Security #: \_\_\_\_\_ NPI# (if applicable) \_\_\_\_\_

(All student and resident activity is tracked throughout our teaching institutions by the SSN. The SSN is the only unique number on any individual. It distinguishes individuals that have identical names, i.e. Robert A. Smith, etc. The database that tracks all teaching activities of Medicare reimbursement purposes requires the SSN). Please be assured, your social security number is strictly confidential and will not be used for any other purposes.

Email 1: \_\_\_\_\_ Email 2: \_\_\_\_\_

**Please check the appropriate category**

Affiliated Fellow       Affiliated Resident       Medical Student       PA Student

**Current Student/Resident Training**

Current Level: \_\_\_\_\_ Academic Year: \_\_\_\_\_

Home Institution: \_\_\_\_\_ Specialty/Program: \_\_\_\_\_

Dates of Residency/Med School Program (beginning – end): \_\_\_\_\_

Current Rotation: \_\_\_\_\_

Dates of Current Rotation: \_\_\_\_\_

**Medical School Information**

Medical School/PA School Attended (include City & State/Country): \_\_\_\_\_

Resident Medical School Graduation Date: \_\_\_\_\_

Medical/PA Student Anticipated Graduation Date: \_\_\_\_\_

**For Foreign Medical Graduates**

ECFMG#: \_\_\_\_\_ Certification Date: \_\_\_\_\_ Letter Only: \_\_\_\_\_

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Revised: 5/28/2010

**RECEIPT AND ACKNOWLEDGEMENT FORM**

**POLICIES:**

I acknowledge that I have read, understand, and agree to abide by the:

- Confidentiality of Patient/Member Information Policy – C201
- Sexual Harassment Policy – C303
- Drug-Free Workplace Policy – C704
- Violent crime Control Act Policy – C530

**GME ORIENTATION SUMMARY:**

I have received the GME Orientation Summary.

**CODE OF CONDUCT:**

I acknowledge that I have received, understand and will abide by the Regions Hospital's Code of Conduct and Corporate Compliance Program.

**ORIENTATION PACKET:**

I acknowledge that I have received the Orientation packet.

***I CERTIFY TO THE BEST OF MY KNOWLEDGE THAT THE INFORMATION ON THIS FORM IS CORRECT AND THAT I HAVE RECEIVED THE ABOVE POLICIES***

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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Revised: 5/28/2010