MIHS
MARICOPA INTEGRATED HEALTH SYSTEM
Maricopa County Special Health Care District

Hello!

Thank you for your interest in Student Education at Maricopa Integrated Health System. We believe our facilities will provide you with outstanding educational opportunities in a student-friendly environment. Come and let us show you what our healthcare providers and community have to offer.

Attached you will find information to help you request a student rotation. We hope this provides a good overview of the requirements for individual students, the application process and timeline, as well as other helpful information.

We wish you all the best in your endeavors.

Mary Ellen Watson
Clerkship Coordinator
Department of Academic Affairs

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MIHS Student On-boarding Process

1. Application and all required documentation is submitted to respective department.

2. Department checks availability and reviews documentation to ensure that student meets departmental/institutional requirements.

   - If student does not meet requirements the school/student is notified.

   - If requested date is not available department may offer alternative rotation dates.

   - Department will contacts Academic Affairs to verify affiliation agreement. If there is not agreement student must provide department with contact information at school for setting up an agreement.

3. Department submits completed application to Academic Affairs for submission to GMEC for final approval.

4. Once approved by GMEC, department will notify student of final approval.

5. Department will communicate information regarding orientation and check-in to student at least 1 week prior to the approved start date.

Due to processing time, completed applications must be submitted at least 2 months in advance. For example: a rotation that is scheduled to begin in the month of August – paperwork must be submitted to Academic Affairs by the 1st of June.

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CLERKSHIP COORDINATORS
2016-2017

PROGRAM	COORDINATOR	EMAIL ADDRESS	PHONE/FAX NUMBER
Emergency Medicine	Darlene Gonzales	darlene_gonzales@dmgaz.org	P 602-344-5804 F 602-344-5907
Family Medicine **(NP – PA Students Only)**	Shannon Jordan	shannon_jordan@dmgaz.org	P 602-344-5513 F 602-468-4517
Internal Medicine	Ginger Reeves	ginger.reeves@mihs.org	P 602-344-5768 F 602-344-1488
Obstetrics/Gynecology	Megan Thielbar	megan.thielbar@mihs.org	P 602-344-5444 F 602-344-5894
Orthopedics	Martina Norrell	martina_norrell@dmgaz.org	P 602-344-1317 F 602-344-1311
Pediatrics	Stephanie Putman	stephanie_putman@dmgaz.org	P 602-344-5885 F 602-344-5941
Podiatry	Desiree Hopf	desiree_hopf@dmgaz.org	P 602-344-5056 F 602-344-5048
Psychiatry	Kelly Sacco	kelly_sacco@dmgaz.org	P 480-344-2028 F 480-344-2157
Radiology	Norma Valverde	norma_valverde@dmgaz.org	P 602-344-1532 F 602-344-1004
Surgery	Donna Benavidez	donna_benavidez@dmgaz.org	P 602-344-5611 F 602-344-5048

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Maricopa Medical Center
2601 E. Roosevelt Street
Phoenix, AZ 85008

APPLICATION FOR CLINICAL ROTATION

PERSONAL DATA

Name: _____
(First, Middle, Last)
Home Address: _____
City, State Zip: _____
Home Phone: _____ Cell Phone:_____
Email Address
Emergency Contact: _____ Telephone: _____

EDUCATION

Student Type: Medical ☐ PA ☐ NP ☐ CRNA ☐

Podiatry ☐ Dental ☐ Other _____

Current School:_____
Start Date:_____ End Date:_____ Degree: _____
Undergraduate School:_____
Mo/Yr _____ to Mo/Yr:_____

Background Information

Have you ever been convicted of a felony? Yes ☐ No ☐

If yes, has the conviction been expunged? Yes ☐ No ☐

Have you ever been sanctioned, excluded or debarred by the federal government from participation in healthcare programs? Yes ☐ No ☐

Have you ever been convicted of a misdemeanor that involved drugs, alcohol related offenses or crimes of moral turpitude? Yes ☐ No ☐

If you have answered yes to any of the questions above please attach a statement of explanation that includes whether or not the offense was expunged and if it has not been expunged why.

Student Name:_____

Rotation Request:_____ Rotation Dates Requested:_____

REQUIRED DOCUMENTATION

Universal Requirements (All student types)

- Curriculum Vitae or Biographical Sketch
- Letter of Good Standing **(excludes Observers)** must include rotation and exact start/end date
- Copy of School ID, Passport or State Issued ID Card
- Certificate of Liability Insurance **(excludes Observers)**
- Proof of Personal Health Insurance
- Acknowledgement of Confidentiality
- Verification of HIPAA Training (can be included in Letter of Good Standing if given at school)
- Background Check (*can be included in Letter of Good Standing. If medical school is unable to provide written verification that a background check has been done then MIHS online background check is required*). A DPS Level 1 Fingerprint Clearance Card will be accepted in lieu of a background check.
- Immunization Requirements
    1. MMR
    2. Hep B,
    3. Varicella (Chicken Pox) Titer
    4. Tetanus (within 10 years), Tdap
    5. TB (within 1 year),CXR or QuantiFeron
    6. Flu Vaccine (Seasonal)

Please submit the information on the MIHS for or if your school has a formatted immunization list please submit otherwise use MIHS form. **Please do not submit lab reports.**

Additional requirements by Student type:

Medical Students Only:

- USMLE/COMLEX/ECFMG Scores Parts 1&2
- Transcripts
- Evaluation Form
- Letter of Interest - Surgery
- Letter of Recommendation (MS4)

***Surgery*:** Letter of interest from student. Two letters of recommendation from the Dean of your school or faculty members.

***Emergency Medicine**:* Students with a planned career in Emergency Medicine will be accepted for rotations from August through January. All applications must be accompanied by a letter of interest from any faculty member stating you are planning a career in EM. Letter of interest needs to be written by someone other than the Dean of your school and cannot be written by the student. Please note that all students **MUST** have USMLE and/or COMLEX.

NP Students Only:

- Preceptor agreement or letter of acceptance

Observers Only:

- Copy of Diploma
- USMLE/COMLEX/ECFMG Scores Parts 1&2
- Institutional Fee - $450.00 (Non Refundable)
- Application Fee - _____

For Internal Medicine Only: Letter of recommendation with minimum 2 months U.S. clinical experience.

Applicant Signature:_____ Date:_____

Department Approved Rotation and Dates:_____

Clerkship Director Signature:_____ Date:_____

MARICOPA
INTEGRATED
HEALTH SYSTEM

Count on us to care.

ACKNOWLEDGEMENT OF CONFIDENTIALITY

I understand that:

- All Maricopa Integrated Health System (MIHS) records are strictly confidential.
- The privacy of patients cared for within the health system must be assured, particularly those patients who are employees of MIHS.
- I must abide by the ethics code of my profession, MIHS Policy #01305 S, Confidentiality/Workforce Member Confidentiality Agreement, the MIHS Standards of Conduct, and the laws of the State of Arizona.
- I will adhere to all data security requirements contained in MIHS Policy #79750 S – MIHS Network Usage Policy.
- Any system identification code given to me is equivalent to my signature.
- Any system information I encounter in the execution of my duties is the property of MIHS and will be held in the strictest of confidence.

I agree:

- To respect every patient's right to privacy and not seek information about a patient unless I am involved in the patient's care.
- Not read or ask about the contents of any medical record unless it is directly applicable to my job or duties.
- To protect the confidentiality of all medical records, whether accessed on-site or off-site, and to use and disclose protected health information only in accordance with MIHS HIPAA policies and procedures.
- Not to repeat or share any information about a patient that I might see or overhear while at MIHS.

Furthermore, I agree:

- Not to read or ask about the contents of MIHS Administrative, personnel, peer review or credentialing records unless it is directly applicable to my duties and responsibilities.
- Not to disclose or reveal the contents of any MIHS Administrative, personnel peer review or credentialing record to anyone who is not directly involved in working with the record unless I have written authorization.
- Not to read or share any non-public, MIHS information that I might see or overhear while at MIHS.

In addition, I agree:

- I will not disclose my unique identification code and/or password to anyone, including my coworkers, supervisor or persons outside of the Health System. Likewise, I will not request others to share their unique identification code or password with me.
- I will ***only*** access MIHS systems using my unique identification code. I will not use or attempt to use another person's unique identification code, nor will I allow others to use my unique identification code.
- I will not attempt to access any information that is not directly required to fulfill my duties and responsibilities.
- If I suspect my security has been compromised, I will notify MIHS Information Technology immediately.

I understand that any breach of the MIHS Policy #01305 S, or my failure to comply with the items listed above could result in disciplinary action up to and including termination of duties, employment, rotation, visit, volunteer status and/or revocation of privileges at MIHS.

Signature _____ Date _____

Employee Name (Please Print) _____ Department Academic Affairs

Last Update: 9/12/2005

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Immunization Requirements

First Name:_____Last Name:_____

PPD (12 months or less):

PPD Date: _____/_____/_____ Result: _____

CXR Date: _____/_____/_____ Result: _____

QuantiFERON:____/____/____ Result:_____

Measles, Mumps, Rubella (MMR) Titers

#1 Date: _____/_____/_____ Positive Measles Date: ___/ ____/____

#2 Date: _____/_____/_____ Positive Mumps Date:____/____/____

Positive Rubella Date:____/____/____

2 Varicella Varicella (Chicken Pox)Titer

#1 Date: _____/_____/_____ Positive Titer Date:____/____/____

#2 Date: _____/_____/_____

3 Hepatitis B Titer

#1 Date: _____/_____/_____ Positive Titer Date:____/____/____

#2 Date: _____/_____/_____

#3 Date: _____/_____/_____

Tetanus (Must be within 10 years) Tdap

Date:____/____/____ Date:____/____/____

Seasonal Influenza Vaccine

Date:____/____/____

HEALTH CARE PROVIDER INFORMATION:

Name:_____

Address:_____

Phone Number :_____

Signature:_____Date:_____