In order to be approved for a Family Medicine Residency rotation at Sampson Regional Medical Center, Intern must provide the following items with the completed application:

- Program Letter of Agreement (PLA)
- Letter of Good Standing and indicate approval of elective and elective dates.
- Proof of adequate malpractice insurance coverage, effective date and expiration date. Required amount of limits of liability, not less than $1,000,000 per incident/ $3,000,000 aggregate.
- Proof of personal hospitalization coverage in effect while visiting student is rotating at Sampson Regional Medical Center. A copy of personal health card is acceptable.
- Proof of current immunizations
- Curriculum Vitae
- Comlex Scores
- Goals, objectives and evaluation form for rotation

If you have any questions or concerns, please contact:

Sampson Regional Medical Center
Graduate Medical Education Office
Post Office Box 260 (28329-0260)
607 Beaman Street
Clinton, North Carolina 28328
910/596-5421
clbarefoot@sampsonrmc.org
To Be Completed by Student: (Please Print or Type)

Name: 

Current Address: 

City: State: Zip: 

Email Address: DOB: Phone: 

Elective: 

DATES: FROM: ____________________ TO: ____________________ 

Alternate Date #2 FROM: ____________________ TO: ____________________ 

Alternate Date #3 FROM: ____________________ TO: ____________________ 

To Be Completed by Sampson Regional Medical Center, Graduate Medical Education

☐ Approved for Dates: FROM: / / TO: / / 

☐ Disapproved: Reason: 

Signature of Individual Approving Rotation Date 

To Be Completed by Dean of Students (or Comparable Official):

Name of Medical School: 

Address: 

City: State: Zip: Phone: 

1. What will be the effective date of fourth-year status? 

2. The student received training in OSHA Universal Precautions: Yes ______ No ______ 

3. The student will receive academic credit for the experience: Yes ______ No ______ 

I certify that the above student is in good academic standing and is approved to register for the requested rotation at Sampson Regional Medical Center. 

Name: ___________________ Title: ___________________ 

Signature: ___________________ Date: ___________________ 

Return: Cheryl Barefoot 
Graduate Medical Education Office 
Post Office Box 260 (28329-0260) 
607 Beaman Street 
Clinton, North Carolina 28328 
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910-596-5421