In order to be approved for a Dermatology 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. One week rotation.

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 Level 1 and 2, and Comlex Level 3 Scores required to be 600 and above. DO NOT APPLY IF SCORES ARE NOT 600 AND ABOVE.

☐ 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
elbarefoot@sampsonrmc.org
Sampson Regional Medical Center
DERMATOLOGY RESIDENCY ROTATION
VISITING INTERN APPLICATION

To Be Completed By Visiting Intern:

Elective Requested: Date: Alternate Date:
FROM: TO: FROM: TO:

To Be Completed By Visiting Intern:

Name:
Current Address:
City: State: Zip:
Email Address: Phone: DOB: SS#:

Name of Sponsoring Institution:
Name of Current Internship Training Program: PGY:
Medical School: Grad Date:

Are you currently doing a Prelim Year: Yes No
If yes, what training program are you planning on entering:

Are you currently licensed to practice medicine: Yes No
If so, please indicate State: License Number:

NPI Number:

Emergency Contact Name: Relationship: Phone:

To Be Signed By Visiting Intern:

I agree to provide all supporting documentation with this application as requested.

Print Name ___________________________ Signature ___________________________

By accepting this Visiting Intern Rotation to the Dermatology Residency Program at Sampson Regional Medical Center, I agree to abide by the rules and regulations of the Hospital and Service to which I am assigned. I understand that Sampson Regional Medical Center will not provide a stipend, professional liability or health insurance.

Print Name ___________________________ Signature ___________________________
To Be Signed By Home Institution Program Director:

I approve the application of ________________________, who is currently enrolled as an Intern in an American Osteopathic Association (AOA) accredited Internship Program.

Home Institution Program Director: ________________________

Date: ________________________

________________________________________
Signature

Home Institution Program Director Name: ________________________

Printed: ________________________

Phone: ________________________

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

☐ Approved for Dates: From: ________________________ To: ________________________

☐ Disapproved: Reason

________________________________________
Signature of Individual Approving Rotation

Date: ________________________

Return: Sampson Regional Medical Center
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Clinton, North Carolina 28328
910-596-5421
clbarefoot@sampsonrmc.org