Sampson Regional Medical Center
FAMILY MEDICINE RESIDENCY ROTATION
VISITING MEDICAL STUDENT APPLICATION

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

☐ Letter of Good Standing

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

☐ Must be a 3rd or 4th year medical student at time of rotation.

If you have any questions or concerns, please contact:

Cheryl Barefoot
Graduate Medical Education Office
Post Office Box 260 (28329-0260)
607 Beaman Street
Clinton, North Carolina 28328
cbarefoot@sampsonrmc.org
910/596-5421
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
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