POMONA VALLEY HOSPITAL
MEDICAL CENTER

Application for Rotation

Please submit this form and required documents via email to rotations@pvhmc.org.

Applicant/ Requestor

First Name: _____ Last Name: _____

Phone: _____ Email: _____

Street Address: _____ City: _____ Zip: _____

Emergency Contact:

Name: _____ Phone: _____

Current Education Level: ☐ Medical Student ☐ Resident/Fellow ☐ Other: _____

Current School/Program Name: _____

Degree Type/Program: _____

Current Education Level: ☐ Year 1 ☐ Year 2 ☐ Year 3 ☐ Year 4

Date range of experience: _____

Day(s) and Time(s): _____

Location of experience (Select One)

☐ PVHMC (Hospital): Department/Unit _____

☐ Other PVH Facility: Clinic/Location _____

What procedures and/or surgeries will be performed within the rotation? Please be specific.

_____

_____

_____

What are the preceptor's main teaching points for the rotation?

_____

_____

_____

What are the school's learning objectives for rotation?

_____

_____

_____

What interact and/or impact might this rotation have on other learners in the hospital?

_____

_____

_____

_____

Applicant Signature: _____ Date: _____

_____

Physician/ Healthcare Professional/ PVHMC Associate

First Name: _____Last Name: _____

Phone: _____Email: _____

☐ I approve the rotation request for the applicant above.. I will provide necessary supervision and ensure applicant's compliance at all times.

Signature: _____ Date: _____

Medical/Clinic Director Approval

First Name: _____Last Name: _____

Phone: _____Email: _____

☐ I approve this medical career experience request.

Signature: _____ Date: _____

Documentation of each Health Requirement listed must be submitted with application form.

All documents must be valid for the duration of experience

1. TB Clearance Document(s) (Select One):

☐ 2 Step PPD (Must be within the last year):

Date of PPD Step 1: _____

Date of PPD Step 2: _____

☐ IGRA - QuantiFERON (Must be within the last year):

Date of QuantiFERON: _____

☐ Chest X-Ray (CXR):

Date of Positive TB Test: _____

Date of Negative CXR (Must be within the last 5 years): _____

2. Measles, Mumps, Rubella Vaccine or Titer (Select One):

☐ MMR Titer:

Date of Positive Titer: _____

☐ MMR Vaccines:

Date of MMR Dose 1: _____

Date of MMR Dose 2: _____

3. Hepatitis B Vaccine or Titer (Select One):

☐ Hepatitis B Titer:

Date of Positive Titer: _____

☐ Hepatitis B Vaccines:

Date of Hepatitis B Dose 1: _____

Date of Hepatitis B Dose 2: _____

Date of Hepatitis B Dose 3: _____

4. Varicella Vaccine or Titer (Select One):

☐ Varicella Titer:

Date of Positive Titer: _____

☐ Varicella Vaccines:

Date of Varicella Dose 1: _____

Date of Varicella Dose 2: _____

5. Date of Tdap vaccination (must be within the last 10 years): _____

6. Date of COVID vaccination(s):

Date of COVID vaccine Dose 1: _____

Date of COVID vaccine Dose 2 (If Applicable): _____

Date of COVID vaccine Booster Dose: _____

7. Date of most recent Flu shot (required October 1 through April 30): _____