POMONA VALLEY HOSPITAL
MEDICAL CENTER

Application for Medical Career Experience

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: ☐ College ☐ Grad School ☐ Other: _____

Current School Name: _____

Degree Type/Program: _____

Schedule of experience:

Date range of experience: _____

Day(s) and Time(s): _____

_____

_____

Location of experience (Select One)

☐ PVHMC (Hospital): Department/Unit _____

☐ Other PVH Facility: Clinic/Location _____

Purpose of shadowing: _____

_____

_____

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): _____

Medical Career Experience and Organized Clinical Education Manual[1]

Medical career experience is available at PVHMC to qualified individuals with a possible interest in the medical profession. Participants must be at least High School Juniors in good academic standing and must have a provider on the Medical Staff who has agreed to serve as their Supervising Medical Staff Provider. They must complete a brief orientation provided by the Office of Academic Affairs and must comply with all orientation and PVHMC requirements and regulations.

- Medical career experience participants will be allowed to observe directly the interaction between the Supervising Medical Staff Provider, patients and PVHMC associates.
- Medical career experience participants will be allowed to observe the identified Physician or Healthcare Professional listed above.
- Medical career experience participants will be allowed to observe at the facility/location and will not be allowed to access any other PVHMC locations/facilities.
- Medical career experience participants will be introduced to each patient who is to be observed, at which time each patient shall have the right to refuse to be observed.
- Medical career experience participants will not be allowed independently to interview or to examine any patients.
- Medical career experience participants will not be allowed to observe any procedures that require aseptic access or any invasive (breast, genital or rectal) exams.
- Medical career experience participants will not be allowed access to medical records and they must maintain all confidentiality requirements outlined during the orientation.

Applicant Signature: _____ Date: _____

Physician/ Healthcare Professional/ PVHMC Associate

First Name: _____ Last Name: _____

Phone: _____ Email: _____

☐ I approve the request for the applicant above to observe me. 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: _____

[1] As listed in the Pomona Valley Hospital Medical Center Medical Staff Bylaws; Medical Career Experience and Organized Clinical Education Manual. Revised September 2018.