POMONA VALLEY HOSPITAL
MEDICAL CENTER

Application for Individual Rotation

Please complete this form and submit to the Department of Academic Affairs.
Please submit via email to group.academic.affairs@pvhmc.org.

Applicant/ Requestor

First Name: _____ Last Name: _____

Phone: _____ Email: _____

Street Address: _____ City: _____ Zip: _____

Emergency Contact Name: _____Emergency Contact Phone: _____

Current School Name: _____ Degree Program: _____

Type of Learner: ☐ Medical Student ☐ Resident ☐ Fellow ☐ NP ☐ PA Other: _____

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

Is the rotation primarily in-patient or clinic based? _____

How much clinic time is included in the rotation? _____

How much in-patient time is included in the rotation? _____

Date range of experience: _____

Schedule for Rotation (eg. Thursdays inpatient and Fridays clinic, surgeries on Thursdays):

_____

_____

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?

_____

_____

Pomona Valley Hospital Medical Center requires TB and MMR clearance to participate in rotation opportunities. Also, between October 1 and April 30, a flu shot is required. Additional health clearance items (Hep B, Varicella, tDap) are encouraged, but not required. Documentation of each completed item is required (Information will be provided after request is approved).

Date of most recent TB clearance (required): _____

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

Date of most recent MMR vaccination or positive titer (required): _____

Date of most recent Hep B vaccination or positive titer (optional): _____

Date of most recent Varicella vaccination or positive titer (optional): _____

Applicant Signature: _____ Date: _____

Physician or Healthcare Professional Information

First Name: _____ Last Name: _____

Phone: _____ Email: _____

Clinic/ Site Location: _____

Please provide a letter from the site director, indicating agreement and including what impact this rotation might have on other learners in the hospital?

Signature: _____ Date: _____

For office use only:

- ☐ *Service Manager notified? Yes ☐ No ☐ _____ (initials)*
- ☐ *Approved by Department of Academic Affairs? Yes ☐ No ☐ _____ (initials)*