4th Year Elective Rotations
Orientation- Student Information

Doctors Hospital
OhioHealth

Please complete the following.

Name:	
SS#:	
Rotation Name:	
Rotation Dates:	☐ 2-Week ☐ 4-Week
Drivers License # and State:	
Local Emergency Contact (if same as in VSAS, leave blank)	
Local Emergency Contact Name:	
Local Emergency Contact Phone:	

I have received the Student Guidelines for Clinical Elective Rotations. I am also aware that Doctors Hospital assumes no responsibility for the completion of my college's rotation evaluation form.

---------- ----------
Signature **Date**

Save this form

Go to **File – Save As**
Name and save form **LastNameFirstName.pdf**.
Email form to Paula Vasu (**Paula.Vasu@ohiohealth.com**)

Medical Education Office Use Only

_____ **Exposure to Potentially Infectious Material Policy**
_____ **Protecting the Information Assets of OhioHealth Confidentiality Statement of Understanding**
_____ **Visiting Student Checkout Policy and Procedure**
_____ **Scrub Training Certificate (if applicable)**