

**OSCEOLA REGIONAL MEDICAL CENTER
MEDICAL STUDENT DELINATION OF LEARNING ACTIVITIES FORM**

MEDICAL STUDENT NAME: _____ PHYSICIAN SPONSOR: _____

ROTATION NAME: _____ ROTATION DATES: _____

The Medical Student:

1. Will, at all times, wear a clearly visible name badge, which identifies him/her as a medical student.
 2. Medical students shall identify themselves to patients as a medical student being supervised by "Dr.'s Name" (attending or resident physician).
 3. Shall interact only with those patients admitted to or being cared for by the attending/resident physician.
 4. Shall perform all activities under the direction of the attending or resident physician
 5. Shall only perform procedures under the direct supervision of the attending or resident physician.
 6. Shall NOT provide orders, written or verbal.
 7. May assist the attending/resident physician with routine patient rounds.
 8. Rounds and medical record entries by the medical student shall not substitute for physician rounds or medical record entries.
 9. May collect clinical and laboratory data for presentation to the attending/resident physician.
 10. May NOT admit patients to the hospital. The admission note is the full responsibility of the attending/resident physician and may not be made by or on the order of the medical student.
 11. The medical student may perform a patient history and examination (PFSH and/or ROS), and document such in the patient's medical record. The medical student note may NOT be referred to in the physician's personal note, nor substituted for the physician note.
 12. Will receive training on the Electronic Medical Record System (EMR) at the beginning of his/her assignment to Osceola Regional Medical Center.
 13. Must use his/her assigned username and password to access EMR documentation. Entering documentation under another provider's username and password misstates authorship and is considered fraud.
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I, the undersigned medical student, request the specifically indicated learning activities as outlined above. No learning activities are requested that do not appear on this form and I understand the granting of such learning activities is subject to verification of my current competency, training and experience. I also recognize that, ultimately, I have no hospital clinical privileges, only the privilege of accompanying and observing my sponsoring physician per these general terms.

_____ **I have discussed first day reporting instructions with the supervising sponsor, as well as any requirements expected to be completed by me prior to the first day of the rotation.**

Signature of Medical Student

Date Signed

I have reviewed the learning activities requested by the applicant medical student and recognize the obligation and responsibility to supervise this individual and ensure that only granted learning activities are utilized. I shall be readily available at all times when the medical student may have questions or needs, and agree to fulfill outlined supervisory responsibilities.

Signature of Sponsor

Date Signed

Please note: Signature of both student and faculty sponsor is required and must be completed before this rotation can begin, otherwise we CANNOT accept the medical student.