Education Application

Name: _____ Date: _____

Phone: _____ Email: _____

Date of birth: _____ Last 4 digits of SSN: _____

Emergency Contact Name: _____

Phone: _____ Relationship to you: _____

Your School: _____

Are you currently seeking a postsecondary degree? ____ Yes ____ No

(If yes, specify degree & major: _____)

Education experience you are requesting:

____ Fellowship in Foot & Ankle ____ Fellowship in Joint Reconstruction

____ Residency (specify specialty or provider: _____)

____ Medical/Nursing/PA School Rotation (specify specialty or provider: _____)

____ Job Shadowing (specify specialty or provider: _____)

Dates requesting for clinical experience at OAM:

_____

I understand that should I need medical attention during or as a result of this clinical experience, I assume full responsibility for any treatments and associated medical costs deemed necessary. I release Orthopaedic Associates of Michigan from all liability.

I understand that all healthcare information, patient care and records are a confidential matter. I agree that all information exchanged while I am observing will be held in strictest confidence.

Signature: _____

Email completed form to rei@oamichigan.com or fax to 616-956-1361.

The following will be required prior to observation:

- Copy of TB testing results less than 1 year old
- Copy of flu vaccination record for current influenza season
- Copy of Covid-19 vaccination record/note declination
- Copy of the front of a photo ID
- Signed Confidentiality Agreement (will be provided)
- Completed Employee ESO and EHO handbook (will be provided) quizzes