

Memorial Healthcare System – Clinical Rotation Checklist

Please complete one form for each student

Student Name: _____ Instructor Name _____

School Name: _____ Program/Discipline _____

Start Date of Clinical Rotation: _____ End Date of Clinical Rotation: _____

MHS Facility: MRH _____ JDCH _____ MRHS _____ MHP _____ MHW _____ MHM _____

Clinical Rotation Areas/Units _____

YES	
	Clinical Rotation/Internship Program Objectives
	Proof of Immunizations
	Proof of health screenings - (including negative PPD OR negative chest X-Ray within the past 12 months)
	Proof of completed background check
	Proof of drug testing
	Proof of CPR for Clinical Students (where applicable)
	Proof of Clinical Instructor's Current License
	Proof of Clinical Instructor's CPR
	Proof of Clinical Instructor's Flu Vaccination Date vaccinated: _____ (as indicated below)

Flu Vaccination Checklist

Instructions:

All students are required to have the Flu vaccine by October 1 of the designated Flu season ending March 31

	Proof of Flu Vaccination for each student. Date vaccinated: _____
	Proof of Medical Exemption from Flu Vaccine from Healthcare Provider –
	Decline Flu Vaccine regardless of reason: A surgical/procedural mask must be worn in all patient care areas throughout the designated influenza season.

I attest by signing these checklists that all information is maintained in the above-named file, and will be provided by the school to Memorial Healthcare System (MHS) upon request.

School Program Director/Manager/Designee Contact Information

Name: _____ Title: _____
Print Name

Signature: _____

Phone Number: _____ Email: _____

Note to Instructors: Please notify your students to keep a copy of the student rotation checklist on file for future use at MHS Facilities. Records cannot be transferred/copied from one facility to another.