UNIVERSITY HOSPITAL
Newark, New Jersey

Hospital Rotation Request Form for Rotators

I. DEMOGRAPHIC INFORMATION (required):

Name: _____ Degree: _____
Last First Middle

Address: _____
Street Address City State Zip Code

Primary Email: _____ Primary Telephone Number: (____) _____

II. ROTATION INFORMATION (required):

Rotation Name: _____Rotation Dates: _____to_____

UH Department: _____ Coordinator: _____

Current School:_____ Professional License number: _____

III. HEALTH STATUS (required): *If Yes to any of the following, must provide explanation*

□ **No** □ **Yes:** Do you have, or have you ever had, any physical or mental health conditions, which may, now or in the future, affect your ability to perform professional clinical or other student duties either with or without reasonable accommodations?

_____

□ **No** □ **Yes:** Do you have, or have you had, any substance or chemical dependency, which may, now or in the future, affect your ability to perform professional clinical or other duties either with or without reasonable accommodations?

_____

IV. DISCIPLINARY ACTION (required): *If Yes to any of the following, must provide explanation*

□ **No** □ **Yes:** Has your association, employment, practice or training at any hospital or healthcare facility ever been voluntarily or involuntarily, in whole or part, limited, suspended, revoked, denied, reduced, surrendered, not renewed, relinquished, subjected to probationary conditions, disciplinary action or have proceedings toward any of those ends ever been instituted or recommended by an official, committee or governing body or are one or more such proceedings, civil and/or criminal, pending in New Jersey State or elsewhere, concerning the above?

_____

□ **No** □ **Yes:** Have you ever been convicted of a misdemeanor, disorderly person's offense, petty disorderly person's offense or a crime (other than minor traffic violations) in this New Jersey State or elsewhere?

_____

I consent to the release of all information to University Hospital, pertaining to my professional qualifications, including but not limited to licensure, training, sanctions, disciplinary actions, criminal background, and/or professional misconduct information that may be required to verify my qualifications and/or the representations I make on this Rotation Request Form.

Signature: _____ Date: _____

UNIVERSITY HOSPITAL
Newark, New Jersey

Required Document List for Rotators

Rotation Request Form and required documents must be submitted 30 days prior to the start of rotation

All Rotators

- ☐ Current criminal background check *(from start of program if no break in service or within past 12 months)*
- ☐ University Hospital Confidentiality Agreement
- ☐ Immunization Attestation Form or Immunization records *(including current PPD and Influenza Vaccination dates)*
- ☐ Copy of governmental ID *(License or Passport)* **and** Copy of current Visa *(if applicable)*
- ☐ Copy of School ID
- ☐ Copy of current Health Insurance Card
- ☐ Proof of completion of required compliance modules - HIPAA, EMTALA and Code of Conduct
- ☐ Completion of Annual Mandatory Online Training for Rotators
- ☐ School Certificate of Insurance - Professional Liability Insurance *(no less than $1MM/$3MM)* and Commercial General Liability Insurance *(no less than $1MM/$3MM)* – *UH must be listed as the certificate holder*

Clinical Rotators with direct patient contact must provide the following additional documentation:

- ☐ Copy of current BLS card *(American Heart Association)*
- ☐ Proof of FIT Testing on one of the following UH approved masks (Kimberly Clark "Tecnol Fluidsheild", 3M "Healthcare Particulate Respirator and Surgical Mask", Secure Guard N95) or Signed Disclaimer for rotators that will not be exposed to patients in isolation units.
- ☐ Students and Non-UH Clinical Evaluators must provide current proof of Individual Malpractice Insurance *(no less than $1MM/$3MM)* if school's Professional Liability does not cover Malpractice (for HSPO policies proof of premium payment is required with certificate) – *UH must be listed as the certificate holder*

I certify that I have reviewed the Hospital Rotation Request Form and all required documentation prior to submitting to the Medical Staff Affairs and Education Office at University Hospital.

Coordinator:_____

Print Name **Signature** **Date**

Office of Medical Staff Affairs and Education
Jennifer Zabala – Program Coordinator
LaToya James – Program Support Specialist
University Hospital – B239 Phone: (973)972-7300 Fax: (973) 972-2848