



CEDARS-SINAI MEDICAL CENTER.

MEDICAL STUDENT INTAKE FORM

Name: _____
Last First Middle Initial

Med Student: 1st Year _____ 2nd Year _____ 3rd Year _____ 4th Year _____

Enrolled in UCLA sponsored Course? Yes _____ No _____ Pager: _____

Social Security Number: _____ Date of Birth: _____

Medical School: _____

Home Address: _____ Citizenship Status: _____

Telephone Number: _____ Home Number: _____ Email Address: _____

Department: SURGERY CSMC Rotation Dates: _____ to _____

Clerkship (Course) Name: _____ Clerkship Number: _____

PLEASE CONFIRM STATUS OF THE FOLLOWING REQUIREMENTS BY CHECKING OFF YES OR NO.

	<u>YES</u>	<u>NO</u>
PPD	_____	_____
IMMUNIZATIONS	_____	_____
MALPRACTICE INSURANCE	_____	_____
HEALTH INSURANCE	_____	_____
SAFETY TRAINING	_____	_____
BLOODBORNE PATHOGEN	_____	_____
HIPAA TRAINING	_____	_____

I RECEIVED A COPY OF HIPAA FACT SHEET FROM CSMC _____

I WATCHED THE HAND HYGEINE VIDEO AT CSMC _____

****NOTE: FOR STUDENTS NOT ENROLLED THROUGH UCLA, PLEASE PROVIDE DOCUMENTATION OF THE ABOVE AS INDICATED.**

Medical Student Signature

CSMC USE ONLY:

- _____ Training Objectives (signed)
- _____ Fire Safety Training Verification Form (signed)

Verified by: _____
Medical Student Coordinator's Signature