Physician Sponsored Student Application

Please complete and email signed application and a copy of your training transcript to physiciansponsoredst@baycare.org.

Incomplete applications will be returned

Date

Required Field

Applicant Information

Last Name | First Name | M.I.

Street Address | Apartment/Unit#

City | State | Zip Code

Phone Number | Email

Anticipated number of rotation hours: | Rotation Start Date | Rotation End Date

Your NE Number: NE | Are you a current BayCare team member? | Employee ID: B

*All answers in this section must be "Yes." If you answered "No" to any of the following questions your application **will be returned**.*

Does your school **and** program have a current Affiliation Agreement with BayCare? *(verify w/ school or email affiliationagreement@baycare.org)*

Did your Physician (MD or DO) Sponsor sign your application?

Did you complete the required Online Learning Center (OLC) trainings?

Has your Hand Hygiene Validation Form been validated by a clinician? *(Not required to be a BayCare clinician)*

Did you export a copy of your OLC training transcript and Hand Hygiene Validation Form to submit with your application?

School Information

School Name

School Contact's First Name | School Contact's Last Name

Phone Number | Email

Student Type

What is your Student Type? | MS/PG Year: | Rotation Specialty/ Department:

Facility Location(s) – Select all that apply – Required Field

- ❑ BayCare Surgery Center-Trinity
- ❑ BayCare Medical Group
  Location:_____
- ❑ Bardmoor Surgery Center
- ❑ Bartow Regional Medical Center
- ❑ Carillon Surgery Center
- ❑ Mease Countryside
- ❑ Mease Dunedin
- ❑ Morton Plant
- ❑ Morton Plant North Bay
- ❑ North Bay Recovery Center
- ❑ Physician Surgery Center
- ❑ South Florida Baptist
- ❑ St. Anthony's
- ❑ St. Joseph's
- ❑ St. Joseph's – Children's
- ❑ St. Joseph's – North
- ❑ St. Joseph's – South
- ❑ St. Joseph's – Women's
- ❑ St. Joseph's Behavioral Health
- ❑ Winter Haven
- ❑ Wesley Chapel
- ❑ Winter Haven Behavioral Health
- ❑ Urgent Care Center
  Location:_____
- ❑ Behavioral Health Outpatient
  Location:_____
- ❑ Behavioral Health Inpatient
  Location:_____

Physician (MD or DO) Sponsor

Physician's Name | ☐ BMG/Employed Physician

By signing, I certify I am an active member of the medical staff and in good standing. I am accountable for the care, treatment and services provided by this student during their approved rotation. It is the responsibility of the physician sponsor to notify his or her insurance carrier. I or my designee will complete any required rotation evaluations.

Physician's Signature: _____ Date: _____