Sampson Regional Medical Center
DERMATOLOGY RESIDENCY ROTATION
VISITING INTERN APPLICATION

In order to be approved for a Dermatology Residency rotation at Sampson Regional Medical Center, Intern must provide the following items with the completed application:

- ☐ Program Letter of Agreement (PLA)
- ☐ Letter of Good Standing and indicate approval of elective and elective dates.
  One week rotation.
- ☐ Proof of adequate malpractice insurance coverage, effective date and expiration date. Required amount of limits of liability, not less than $1,000,000 per incident/ $3,000,000 aggregate.
- ☐ Proof of personal hospitalization coverage in effect while visiting student is rotating at Sampson Regional Medical Center. A copy of personal health card is acceptable.
- ☐ Proof of current immunizations
- ☐ Curriculum Vitae
- ☐ Comlex Level 1 and 2, and Comlex Level 3 Scores required to be 600 and above.
  DO NOT APPLY IF SCORES ARE NOT 600 AND ABOVE.
- ☐ Goals, objectives and evaluation form for rotation

If you have any questions or concerns, please contact:

Sampson Regional Medical Center
Graduate Medical Education Office
Post Office Box 260 (28329-0260)
607 Beaman Street
Clinton, North Carolina 28328
910/596-5421
clbarefoot@sampsonrmc.org

Sampson Regional Medical Center
DERMATOLOGY RESIDENCY ROTATION
VISITING INTERN APPLICATION

To Be Completed By Visiting Intern:

Elective Requested:	Date:		Alternate Date:	
	FROM:	TO:	FROM:	TO:

To Be Completed By Visiting Intern:

Name:		
Current Address:		
City:	State:	Zip:
Email Address:	Phone:	DOB: SS#:
Name of Sponsoring Institution:		
Name of Current Internship Training Program:		PGY:
Medical School:		Grad Date:
Are you currently doing a Prelim Year: Yes No		
If yes, what training program are you planning on entering:		
Are you currently licensed to practice medicine: Yes No		
If so, please indicate State:		License Number:
NPI Number:		
Emergency Contact Name:	Relationship:	Phone:

To Be Signed By Visiting Intern:

I agree to provide all supporting documentation with this application as requested.

Print Name

Signature

By accepting this Visiting Intern Rotation to the Dermatology Residency Program at Sampson Regional Medical Center, I agree to abide by the rules and regulations of the Hospital and Service to which I am assigned. I understand that Sampson Regional Medical Center will not provide a stipend, professional liability or health insurance.

Print Name

Signature

To Be Signed By Home Institution Program Director:

I approve the application of ______________________________________, who is currently enrolled as an Intern in an American Osteopathic Association (AOA) accredited Internship Program.

Home Institution Program Director: Date:

____ ________________________

Signature

Home Institution Program Director Name:

____ ________________________

Printed Phone:

To Be Completed by Sampson Regional Medical Center, Graduate Medical Education

☐ Approved for Dates: From: To:

☐ Disapproved: Reason

____________________________________ ____________________

Signature of Individual Approving Rotation Date

Return: Sampson Regional Medical Center
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