Catholic Health System
Medical excellence with a tradition of caring.

Visiting Student/Resident Attestation Form

Department: _____ Dates: _____

Name: _____
(First) (Middle) (Last)

Home Address: _____

Telephone: _____ Pager: _____ Cell Phone: _____

Email: _____ Date and Place of Birth: _____

Medical School: _____ Degree: _____ Year: _____

Current Training Level: _____

Sponsoring Institution, Program or Physician: _____

COMMENTS: _____

_____

In registering as a Visiting Student/Resident, I acknowledge that I am aware that an affiliation agreement exists between my sponsoring institution and this facility. Patient contact will be limited to the discretion of the sponsoring physician.

I have received an orientation packet, reviewed the information herein, and agree to abide by the mission, philosophy and standards set forth by the Catholic Health System.

AN AFFILIATION AGREEMENT EXISTS BETWEEN THIS FACILITY AND THE EDUCATIONAL INSTITUTION WHICH YOU ATTEND. IF IMMUNIZATION RECORDS ARE NEEDED DURING MY ROTATION, THEY CAN BE RETRIEVED FROM MY MEDICAL SCHOOL.

_____ _____

Signature: Observing Visitor Date *Signature: Department Chair Date*

_____

Signature: Director of Med Education Date