

## Medical Student Rotation Application

The Medical Student Rotation Program teaches students/ residents essential clinical and practical skills. Participating students rotate with Peconic Bay Medical Center and participating site's faculty and residents in a variety of areas.

### Application Process

A completed rotation packet must be sent to **Brittany Blake**. Please indicate on the application the preferred dates of rotation. Our rotations are four (4) weeks in length.

**All required documents must be sent to the Brittany Blake AFTER your rotation request has been confirmed.**

Send PDF rotation packet, supporting documentation, and picture ID to:

[bblake2@northwell.edu](mailto:bblake2@northwell.edu)

### Rotation Requirements

The following is required in order to begin your rotation. Please make sure all supporting documents are sent to Brittany Blake at least one month prior to your rotation.

#### Medical Student Prerequisites

All prerequisites must be met before you are approved for a rotation. This includes the completion of all core rotations and status as a final year medical student when you are scheduled to participate in the rotation.

#### Health Requirements

The Office of Medical Education requires medical students to provide proof of the following immunizations:

- Proof of Varicella Rubella, Rubella immunity (serology)
- Proof of Hepatitis B immunity (serology)
- Annual Tuberculosis Screening
- Annual Flu vaccine (during flu season)
- T-Dap
- COVID 3 Series

All students must provide health documentation to begin a scheduled rotation.

#### Cancellation Policy

Once your assignment has been confirmed, either by phone and/or mail, you are expected to complete the rotation. While cancellation may be necessary, please do so at least 60 days in advance.

#### Parking

Parking is available down the road from the hospital. The address of the parking lot is 765 Old Country Road, Riverhead NY. There is a shuttle to the hospital provided at no charge.

#### White Coats

Be sure to bring your white coat; it is required that you wear one while on the premises of Peconic Bay Medical Center or any off-site clinics.

#### Miscellaneous

Students are expected to bring their own diagnostic equipment and textbooks.



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**Rotations Offered:** \*Circle rotation being completed\*

- **Family Medicine (Audition or Sub-I/Elective)**
    - o (If you are interested in our Family Medicine Residency, please indicate this is an "audition" rotation"
- **Internal Medicine**
  - **Critical Care/ ICU**
  - **Gastroenterology**
  - **General Surgery (Sub-I/ Elective)**

### Trainee Information:

**\*Please Circle Below\***

Name \_\_\_\_\_ Gender:  Female  Male  Other

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Cell Carrier \_\_\_\_\_

Email Address (preferred) \_\_\_\_\_ or \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

### Rotation Selection

Name of Rotation: \_\_\_\_\_

Rotation Dates:

FIRST CHOICE:

SECOND CHOICE:

Have you rotated at Peconic Bay Medical Center or another Northwell Hospital? Yes or No

If you answered yes, what was your universal ID assigned to you for your rotation?

### School/Program Information

School/ Affiliated Institution: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

## Medical Student Rotation Application

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

School Placement Coordinator: \_\_\_\_\_

Phone \_\_\_\_\_ Email Address \_\_\_\_\_

Year in School (During Rotation): \_\_\_\_\_ Anticipated Graduation Date: \_\_\_\_\_

Planned Specialty: \_\_\_\_\_

*I certify that the above information is correct to the best of my knowledge at the date of this application. I also understand that completing this application does not guarantee an offer of placement by Peconic Bay Medical Center.*

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

**The following documents must be submitted to the Graduate Medical Education Office:**

- Photo ID- Driver's License or Passport
- Computer Access Forms
- HIPAA Acknowledgement Form
- Health Information- Immunizations Including:
  - Proof of Varicella Rubella, Rubella immunity
  - Proof of Hepatitis B immunity
  - Annual Tuberculosis Screening
  - Annual Flu vaccine (during flu season)
  - T-Dap
  - COVID
- Surgery
  - **Cornerstone Modules**