



Student ID Badge Request Form for Locations:

Memorial Hospital Miramar

Student ID Badge Cost:

\$10.00 Deposit Required. Cash, No Coins Accepted and Exact Change Only.

Badging Location and Days/Hours:

MHM Human Resources Office, Medical Office Building.

Monday, Wednesday & Friday, 9:00 am – 11:00 am.

Tuesday & Thursday 2:00 pm – 4:00 pm.

Please Print Clearly and Follow All Instructions for Obtaining ID Badge:

Students must complete this form in its entirety, print it out and bring this form to Human Resources **at least one week prior to the rotation start date.** At the end of the rotation student must return the badge to Human Resources in order to receive their badge deposit back.

Please refer to the map for student parking. Students are only permitted to park in the lot indicated on the map as "STUDENT PARKING". The lot is located on the far SOUTH side of the hospital's perimeter road (across from the Medical Office Building). Students are not allowed to park in the visitors' areas.

***THIS BADGE IS PROPERTY OF MEMORIAL HEALTHCARE SYSTEM. YOU MUST RETURN YOUR BADGE TO HUMAN RESOURCES OFFICE WITHIN 30 DAYS OF THE DATE PRINTED ON YOUR BADGE TO RECEIVE YOUR DEPOSIT AND AVOID LEGAL RAMIFICATIONS.**

FULL FIRST, FULL MIDDLE AND LAST NAME

LAST: _____ FIRST: _____ MIDDLE: _____

FULL ADDRESS: _____ CITY/ST/ZIP: _____
(NO P.O. BOX ALLOWED)

DATE OF BIRTH: _____ CELLULAR: _____

SCHOOL: _____ ROTATION ENDS ON: ____/____/____

DRIVER'S LICENSE #: _____

Lost badge replacement fee is \$5 each time.

Student's Signature: _____

Human Resources' Signature: _____
Student Badge ID Request Form/August 2016 (replaces all others)

Memorial Healthcare System

Clinical Rotation Checklist

Student Name: _____ Instructor Name _____
School Name: _____ Program/Discipline _____
Start Date of Clinical Rotation: _____ End Date of Clinical Rotation: _____
Clinical Rotation Areas/Units _____

Present	
Yes	
	Proof of Flu Vaccination for each student
	Proof of Medical Exemption from Flu Vaccine from Healthcare Provider
	Proof of declination of Flu Vaccine
	Proof of Clinical Instructor's Flu Vaccine, License/CPR

I attest by signing this checklist that all information is maintained in the above-named file, and will be provided by the school to Memorial Healthcare System (MHS) upon request.

School Program Director/Manager Contact Information

Name: _____ Title: _____
Print Name

Signature _____

Phone Number: _____ Email: _____

Note to Instructors: Please notify your students to keep a copy of the student rotation checklist on file for future use at MHS Facilities. Records cannot be transferred/copied from one facility to another.

Thank You.