



CEDARS-SINAI MEDICAL CENTER.

MEDICAL STUDENT INTAKE FORM

Name: _____
Last First Middle Initial

Med Student: 1st Year ___ 2nd Year ___ 3rd Year ___ 4th Year ___

Enrolled in UCLA sponsored Course? Yes ___ No ___ Pager: _____

Social Security Number: _____ Date of Birth _____

Medical School: _____

Home Address: _____ Citizenship Status: _____

Telephone Number: _____ Home Number: _____ Email Address: _____

Department: _____ CSMC Rotation Dates: _____ to _____

Clerkship (Course) Name: _____ Clerkship Number: _____

PLEASE CONFIRM STATUS OF THE FOLLOWING REQUIREMENTS BY CHECKING OFF YES OR NO.

	<u>YES</u>	<u>NO</u>
PPD	___	___
IMMUNIZATIONS	___	___
MALPRACTICE INSURANCE	___	___
HEALTH INSURANCE	___	___
SAFETY TRAINING	___	___
BLOODBORNE PATHOGEN	___	___
HIPAA TRAINING	___	___
I RECEIVED A COPY OF HIPAA FACT SHEET FROM CSMC	___	___
I WATCHED THE HAND HYGIENE VIDEO AT CSMC	___	___

****NOTE: FOR STUDENTS NOT ENROLLED THROUGH UCLA,
PLEASE PROVIDE DOCUMENTATION OF THE ABOVE AS INDICATED.**

Medical Student Signature

CSMC USE ONLY:

- ___ Training Objectives (signed)
- ___ Fire Safety Training Verification Form (signed)

Verified by: _____
Medical Student Coordinator's Signature