Wisdom. Compassion. Integrity.

School Externship Checklist

School:_________________________________

Program:_______________________________

Semester/Term Date:____

Clinical Coordinator:____________________________________

Contact Phone:____

Contact E-Mail:___________________________________

Name of Student:_______________________________________

Galen location where clinical will take place/Supervising Physician:_______________________________________

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Date Range of Clinical Rotation:_______________________________________

Required Documentation	**Comments and/or mark (X)**
Approved background check	
Negative urine drug screen	
Proof of Hep B Series	
Proof of flu vaccine (September-April)	
Proof of Tdap Vaccine (recommended if working in pediatrics)	
Copy of negative TB skin test or negative chest x-ray within the last 12 months	
Proof of malpractice insurance through school	
Up to date clinical affiliation agreement	

This is to verify that the student is in good standing at your school and has been trained in Infection Prevention & Control, Bloodborne Pathogens, and HIPAA.

By signing this form, the educational institution confirms the elements above are current for the semester/term for each faculty and student. The school agrees to provide any information from the faculty or student upon request.

School Signature:____ Date:__________________

Printed Name:____ Title:____________________________