Physician Sponsored Student Application

Please complete and email signed application and a copy of your training transcript to physiciansponsoredst@baycare.org.

Incomplete applications will be returned

Date

Required Field

Applicant Information

Last Name | First Name | M.I.

Street Address | Apartment/Unit#

City | State | Zip Code

Phone Number | Email

Anticipated number of rotation hours: | Rotation Start Date | Rotation End Date

Your NE Number: NE | Are you a current BayCare team member? | Employee ID: B

COVID-19 Vaccination Status: | Date Fully Vaccinated/Exemption Approval Date:

All students who come on-site to any BayCare facility as defined by Center for Medicare/Medicaid Services guidelines must be fully vaccinated or have an exemption.

Disclaimer: Upon BayCare request, you or your school will need to provide documentation verifying the above information (proof of vaccination/exemption)

School Information

School Name

School Contact's First Name | School Contact's Last Name

Phone Number | Email

Student Type

What is your Student Type? Please make a selection. | MS/PG Year

Facility Location(s) – Select all that apply – Required Field

- ❑ BayCare Surgery Center-Trinity
- ❑ BayCare Medical Group
- ❑ Bardmoor Surgery Center
- ❑ Bartow Regional Medical Center
- ❑ Carillon Surgery Center
- ❑ Mease Countryside
- ❑ Mease Dunedin
- ❑ Morton Plant
- ❑ Morton Plant North Bay
- ❑ North Bay Recovery Center
- ❑ Physician Surgery Center
- ❑ South Florida Baptist
- ❑ St. Anthony's
- ❑ St. Joseph's
- ❑ St. Joseph's – Children's
- ❑ St. Joseph's – North
- ❑ St. Joseph's – South
- ❑ St. Joseph's – Women's
- ❑ St. Joseph's Behavioral Health
- ❑ Winter Haven
- ❑ Wesley Chapel
- ❑ Winter Haven Behavioral Health
- ❑ Urgent Care Center
- ❑ Behavioral Health Outpatient

Location:____________________

- ❑ Behavioral Health Inpatient

Location:____________________

Physician (MD or DO) Sponsor

Physician's Name | ☐ BMG/Employed Physician

By signing, I certify I am an active member of the medical staff and in good standing. I am accountable for the care, treatment and services provided by this student during their approved rotation. It is the responsibility of the physician sponsor to notify his or her insurance carrier. I or my designee will complete any required rotation evaluations.

Physician's Signature: ______________________________ Date: ___________________