Internal Medicine Residency Program
Kaiser Permanente Fontana Medical Center

Greetings!

Thank you for your interest in the Internal Medicine Residency at Kaiser Permanente Fontana Medical Center. Attached is our application for Clerkship. We offer the following experiences:

- Inpatient Medicine Wards (2 - 4 slots monthly)
- Pulmonary Medicine (1 slot monthly)
- ICU Rotation (1 slot monthly)
- Ambulatory Internal Medicine (1 slot monthly)

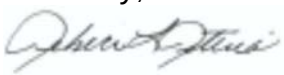
All applications are reviewed on a case-by-case basis and must be complete before they are submitted to our Program Director for review/approval. Process is as follows:

1. Completed application is received with all supporting documents.
2. Calendar is reviewed for open slots, we require a minimum of 3 choices.
3. If there is availability, application is reviewed by the Program Director.

Applicant will be emailed upon approval, denial or if there are no slots available. Please allow up to 4 weeks for complete approval process before you follow up with the office. You may email your application or send via US mail, FAX is not accepted. We understand that your school may need to send documents separately; again, email is acceptable.

Program Director reserves the right to deny application based on academic performance or test scores. Our clerkship program is very competitive and we have a number of applications that come through VSAS. All slots are first-come, first-served, based on receipt of complete application.

Sincerely,



Rebecca Renteria
Program Administrator

Internal Medicine Residency
Kaiser Permanente Fontana Medical Center

Attachments (2)

Name (please print) _____

Current Address: _____ _____ _____ _____
STREET CITY STATE ZIP

Permanent Address: _____ _____ _____ _____
STREET CITY STATE ZIP

Phone Numbers: Cell: _____ Home: _____

Email: _____

Title: Medical Student -_____ yr Specialty of Interest/Training _____

Have you been awarded a Kaiser Permanente scholarship? ☐Yes ☐No If so, please provide name of the award and year:

_____

Have you completed a previous clinical rotation with Kaiser Permanente? ☐Yes ☐ No If yes, please specify date, location, specialty, and mentoring physician:

_____

ROTATION DATES REQUESTED

Rotation Specialty _____ Location/Medical Center: SBC - Fontana Med Ctr

Dates Requested: **YOU MUST INDICATE A MINIMUM OF 3 CHOICES. FAILURE TO DO SO MAY DELAY PROCESSING!**

1st Choice: _____ to _____ 2nd Choice: _____ to _____ 3rd Choice: _____ to _____

MEDICAL EDUCATION

Medical School _____

Address _____ _____ _____ _____
STREET CITY STATE ZIP

Country _____ Start Date: _____ Graduation Date (or expected):_____

Contact: _____ Email:_____

POST-GRADUATE EDUCATION

☐ N/A

Institution_____

Address_____ _____ _____ _____
STREET CITY STATE ZIP

Program Director: _____ Phone/E-mail: _____

Start Date: _____ Expected Completion: _____ Accreditation: ☐ACGME ☐AOA

PGY/Position: _____ Specialty _____

Institution_____

Address_____ _____ _____ _____
STREET CITY STATE ZIP

Program Director: _____ Phone/E-mail: _____

Start Date: _____ Expected Completion: _____ Accreditation: ☐ACGME ☐AOA

PGY/Position: _____ Specialty _____

Please include any additional experiences on the last page of this form

PRE-APPROVAL DOCUMENTS INCLUDED WITH THIS APPLICATION

	Enclosed?
Letter of Agreement and Good Standing from Dean of Student Affairs	☐Yes ☐No
Malpractice insurance statement	☐Yes ☐No
Official Medical School Transcript	☐Yes ☐No
Copy of USMLE or COMLEX Transcript	☐Yes ☐No
Personal Statement/Letter of Intent	☐Yes ☐No
Copy of License/Photo ID	☐Yes ☐No
Kaiser Health Form & Proof of Immunizations	☐Yes ☐No
Current BLS or ACLS	☐Yes ☐No
Current DEA & Medical License (if applicable)	☐Yes ☐No ☐N/A

Personal Statement should address the following questions (be specific and detailed):

- Why do you want to rotate in Internal Medicine at Fontana Medical Center?
- What are your future plans in medicine?

EXAMINATIONS/LICENSURE/CERTIFICATIONS

Please list the scores for the examinations you have completed:

USMLE: Step I _____ Step II _____ Step III _____

COMLEX: Part I _____ Part II _____ Part III _____

NBME, Part I score _____ NBME, Part II _____

Do any of these scores reflect multiple examination attempts? ☐Yes ☐No

If yes, please specify test and number of attempts: _____

Please complete all, as applicable:

Medical License # and State _____ Expiration Date _____

DEA #_____ Expiration Date _____

Do you have any of the following certifications? ☐BLS ☐ ACLS ☐ PALS ☐Fluoroscopy

ATTESTATION

I attest that I am in good standing with my program and the information I have provided within this application is truthful and accurate to the best of my knowledge. I understand that any false or missing information may disqualify me from this position. I further declare that by submitting this application, I authorize the Kaiser Permanente and its representatives to contact persons associated with hospitals and institutions at which I have studied or trained and well as individuals whose names I have submitted in connection with this application. I hereby release from liability all representatives of the hospital and its professional staff for references performed in good faith in connection with evaluating my application and credentials; and release from liability all individuals and organizations that in good faith provide information to Kaiser Permanente, including otherwise privileged or confidential information.

Applicant Signature_____**Date:** _____

ATTN: AMERICAN UNIVERSITY OF THE CARIBBEAN (AUC) STUDENTS MUST HAVE COMPLETED ALL CORE ROTATIONS AT KERN COUNTY, PROVIDE AN EVALUATION FROM A PREVIOUS ROTATION, AND HAVE A MINIMUM SCORE STEP 1 OF 200.

KAISER PERMANENTE®
Medical Care Program
Southern California Region

PRINT NAME _____

HEALTH STATUS INFORMATION

According to the policy and procedures of Regional Human Resources (HR 5.02) Southern California Region, Title 22, CAC Section 7023, CDC guidelines all contracted medical center employees are required to demonstrate current immunity to the following communicable diseases:

1. Complete the following serology OR immunization information:
(Serologic immunity OR up-to-date immunization is required.)

Mumps	Serologic Titer:	Date of Titer	Immunization Date*:1. 2.
Rubella	Serologic Titer:	Date of Titer	Immunization Date*:
Rubeola	Serologic Titer:	Date of Titer	Immunization Dates*:1. 2.
Varicella	Serologic Titer:	Date of Titer	Immunization Dates*:1. 2.
Hepatitis B	Serologic Titer:	Date of Titer	Immunization Dates*:1. 2.
			3.

*Give the last time immunized. Childhood vaccinations are not sufficient. The following number of doses are needed: two doses for rubeola; two doses for varicella; at least the first dose for hepatitis B. Hepatitis B vaccine can be declined, if so please sign below in section 4.

2. Give the following tuberculosis screening information:

Provide documentation of your most recent PPD skin test. If the PPD was positive, give date and results. The last PPD needs to be in the last year before starting work.

Last PPD Date:	Results (mm of induration)*:
Previous PPD Date:	Results (mm of induration)*:

*If there was no induration, indicate "0".

If your PPD is newly positive, you will need to provide a report of a negative chest x-ray done after the PPD. If the PPD was previously positive, the results of a negative chest x-ray should be on file at your registry.

3. Please answer the following questions:

☐Yes ☐No Have you had any new problem which **currently** is infectious or would prevent you from performing your assigned duties at this time? If "Yes", describe:_____

☐Yes ☐No Have you had an unexplained weight loss in the last year? If "Yes", give amount lost:_____

☐Yes ☐No Do you have a persistent cough (lasting 3 weeks or more)?

☐Yes ☐No Do you cough up blood?

☐Yes ☐No Do you have persistent, unexplained fevers or night sweats?

☐Yes ☐No Do you have a rash? If "Yes", for how long?_____

☐Yes ☐No Have you seen a doctor for any of the above? If "Yes", which numbered item?

4. Hepatitis B vaccine: I understand that due to my occupational exposure to blood or other potentially infectious material, I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine at no charge to myself. However, I decline hepatitis B vaccination at this time. I understand by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me. Sign if you want to decline the Hepatitis B vaccine. Signature: _____

5. Tdap vaccine/date _____or declination _____ **6. Seasonal flu vaccine/date** _____ or declination _____**If cannot receive the flu vaccine due to medical or religious reasons and still intends to rotate through patient care areas, he/she will be required to provide written verification from a clergyperson or healthcare provider to Physician/Nursing Education as well as don a surgical mask during all patient care. This would be in effect during the traditional flu season months of October through April.**

I hereby affirm that the information provided in this questionnaire is accurate and fairly represents my current health status. I understand that any misrepresentations, misstatements or omissions in this questionnaire, whether intentional or not, shall constitute a breech of contract between Contractor, or contract agency, and Kaiser Permanente. If employment was initiated prior to the discovery of such misrepresentation(s), misstatement(s) or omission(s), such discovery may result in immediate suspension or termination of such employment. I understand my employer/agency will receive a copy of this completed form.

_____ _____/_____/_____
SIGNATURE PHONE DATE

☐ Resident ☐ Intern ☐Medical Student ☐Nursing Student ☐Visiting Faculty

HEALTH SCREENING REQUIREMENTS

COPIES OF LABORATORY REPORTS AND/OR IMMINIZATION RECORDS MUST BE ATTACHED.

RUBEOLA (Measles)
1. Laboratory evidence of immunity

OR

2. Written documentation showing adequate vaccination:
   1st dose (first dose given)
   2nd dose (≥4 wks later)

MUMPS
1. Laboratory evidenced of immunity

OR

2. Written documentation showing adequate vaccination:
   1st dose (first given)
   2nd dose (4 weeks later)

RUBELLA (German measles)
1. Laboratory evidence of immunity

OR

2. Written documentation showing adequate vaccination:
   One (1) dose administered

VARICELLA (Chickenpox) ***History of disease not accepted**
1. Laboratory evidence of immunity

OR

2. Written documentation showing adequate vaccination:
   1st dose (first dose given)
   2nd dose (4-8 wks later)

HEPATITIS B
1. Laboratory evidence of immunity

OR

2. Written documentation of Hepatitis B immunization program begun:
   1st dose
   2nd dose
   3rd dose
   [+] HBsAb ≥90days

OR

3. Signed declination to receive HBV vaccine **(NOTE: physicians not exempted, must start vaccination series)**

TB SCREENING (PPD administered intradermally, results measured and **recorded in millimeters induration** at 48-72 hrs)

1. **IF PPD NEGATIVE**, must demonstrate (or produce written documentation of same)
   R non-reactive PPD within last 3 months
   AND
   R second non-reactive PPD within preceding 12 months.

NOTES
- **If no PPD in last 12 months, 2-step PPD testing is required by state & federal law**
- **Federal law (OSHA) prohibits healthcare worker from measuring, recording his/her own PPD**
- **History of reactive PPD following receipt of BCG is not accepted in lieu of documentation**

2. **IF PPD POSITIVE**, must demonstrate (or produce written documentation of same)
   R documentation of reactive PPD and/or INH therapy
   AND
   R chest xray within last year

MUST ATTACH :
- R Health screening questionnaire (which includes TB signs, symptoms) completed in last twelve (12) months
- R Latex allergy screening (separately, or as part of general health screening questionnaire)
- R Hepatitis B vaccine declination, if HBsAb negative and applicant refuses vaccination (except physicians)