Dear Applicant,

This application is for visiting medical students and residents wanting to shadow a physician staff member in a Carilion facility. Success in arranging this visit depends largely on how carefully you read and follow the directions.

During the visit, students may not participate in patient care by touching patients, interacting with patients, or assisting in procedures even with preceptor approval and encouragement. This is not an opportunity to be precepted: you may not ask questions or interject comments unless the preceptor asks you directly.

All arrangements must be coordinated with Carilion's Visiting Student Affairs Office as described here and on the application even if your school or a Carilion staff member consented to the visit. Only after receiving a confirmation email from VSA should you make plans to come.

Key factors to consider before applying

- Maximum time: During a given academic year, students may shadow 3 times in the clinical area of interest for 4-8 hours each time. Dates do not have to be consecutive.
- Placement is not guaranteed but depends on space limitations and your successfully completing the application in time as described below.
- Missed Opportunities: Shadow visits will not be rescheduled.
- Taking call: You may not take call through the hospital's call system.
- Housing is not provided.

Process

In order to apply, complete the application on-line, if possible, following the directions here and on the application. We cannot process incomplete applications, faxed or scanned applications, those missing information or documentation, or those arriving fewer than 30 or 15 days in advance as described below.

Complete all areas of the application and insure all required documentation that you must provide is attached.

- **If a Carilion staff member already agreed to let you shadow,** choose the first option on the application and follow those directions. Return the completed application packet to so that it arrives at Visiting Student Affairs at least 15 days prior to the first date listed on the application. **No exceptions.**

- **If you want Visiting Student Affairs to find a staff member you may shadow,** choose the second option and follow those directions. Return the completed application packet to so that it arrives at Visiting Student Affairs at least 30 days prior to the first date listed on the application. **No exceptions.**

When received, applications are reviewed for completion. Completed applications are processed, but incomplete applications are filed in an unattended drawer. Do not make plans to come until you receive an email with “Confirmation” in the subject line.

Please save this cover letter for future reference and remember that the more thorough you are in completing the application, the more quickly we can arrange the visit.

Visiting Student Affairs
CRMH, 1 South
1906 Belleview Avenue, SE
PO Box 13367
Roanoke, VA 24033-3367
VisitingStudentAffairs@carilionclinic.org

CARILION CLINIC

Visiting Medical Student & Visiting Resident Observation/Shadow Application

PRINT LEGIBLY or complete on-line. The application must be completed and on file with Carilion's Visiting Student Services Office as described on the application cover letter and below.

Name _____ ☐**M or** ☐**F** _____ _____
First Middle Last — Official Program Email Address — Mobile Number

Address _____ _____ _____ _____
Street, City, State, Zip Code — Last 4 digits of SSN — Birthday (MM/DD/YY) — Home Phone

CITIZENSHIP/VISA STATUS Check One (Not Optional)

☐ Native-Born US Citizen
☐ Naturalized US Citizen
☐ Permanent Resident
☐ B1, B2 Temporary Visa
☐ F1 Student
☐ J1, J2 Exchange Visitor

Emergency Contact _____
Relationship _____
Phone Numbers _____

ATTACH PASSPORT-TYPE PHOTO HERE

Check those that apply: ☐**MS1** ☐**MS2** ☐**MS3** ☐**MS4** ☐**Medical School Graduate**
☐**PGY1** ☐**PGY2** ☐**PGY3** ☐**PGY4**

_____
Medical School or Residency Program and Location (City, State, Zip Code)

Clinical Office Contact _____ Phone _____ Email _____

1. Select One of the Following Options

☐ If a Carilion staff member has already agreed to let you shadow, fill in each blank here and send the completed packet so that Visiting Student Affairs has it at least 15 days prior to the first date listed in the date section below.

Preceptor's Name _____ **Phone** _____ **Email** _____

_____ _____ _____
Practice Name and Location — Office Contact — Phone

☐ If you want Student Affairs to find a staff member for you to shadow, fill in each blank here and send the completed packet so that Visiting Student Affairs has it at least 30 days prior to the first date listed in the date section below.

Requested departments or areas of interest: _____

At any of these facilities:
☐ Carilion Medical Center, Roanoke
☐ Carilion Franklin Memorial Hospital
☐ Carilion Stonewall Jackson Hospital
☐ Carilion New River Valley Medical Center
☐ Carilion Giles Memorial Hospital
☐ Carilion Tazewell Community Hospital
☐ Other _____

2. Select Preferred Dates/Times (List several dates allowing sufficient time to meet the date restrictions on the cover letter.)

_____, ☐ and ☐ or _____, ☐ and ☐ or _____, ☐ and ☐ or _____

- **Incomplete applications and those arriving past the due date** are not processed **(no exceptions).**
- **All arrangements must be coordinated through Carilion's Visiting Student Affairs Office.**
- **Do not make plans to shadow before receiving confirmation by email from the Visiting Student Affairs Office.**
- **Students may shadow only as listed here and on the Sponsor Agreement.**

ENCLOSE THESE DOCUMENTS

☐ Letter of Good Standing from school or program
☐ Carilion Immunization Record (left column)
☐ Carilion Access & Confidentiality Agreement (left column)
☐ Carilion Student Participation Agreement (left column)
☐ Carilion Observer Guidelines (left column)
☐ Proof of Health Care Coverage (photocopy both sides of your health insurance card)

M4'S AND RESIDENTS, IF YOU ARE INTERESTED IN RESIDENCY AT CARILION, ENCLOSE THE FOLLOWING.

☐ Copy of Transcripts
☐ Copy of USMLE or COMLEX Scores

I CERTIIFY THAT THE INFORMATION SUBMITTED ON THIS APPLICATION IS COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

_____ _____ _____
Signature — Date — Print Your Name

Print Form

Mail originals, **DO NOT FAX,** to **Visiting Student Affairs, CRMH, PO Box 13367, Roanoke, VA 24033-3367**
visitingstudentaffairs@carilionclinic.org