CLINICAL ENRICHMENT EXPERIENCE

MICHIGAN STATE UNIVERSITY COLLEGE OF OSTEOPATHIC MEDICINE

This form is required for participation in a clinical enrichment experience outside a scheduled rotation or during out time. No credit will be given for this experience, nor will it appear on the student's schedule or transcript. Students cannot participate if they have already hit their 80 hour per week maximum. If assistance is required, please contact the Medical Education Coordinator or the MSUCOM Office of the Registrar.

1. TO BE COMPLETED BY THE STUDENT (REQUIRED):

Name: _____ ☐ MS3 ☐ MS4

Scheduled Rotation Information (primary priority):

Begin & End Dates: _____ Service: _____ Location: _____Supervising Physician: _____

Enrichment Experience:

Date(s):_____ Service: _____ Location: _____ Supervising Physician: _____

By my signature, I acknowledge that my first priority is to the requirements of my scheduled rotation. Additionally, I understand that if I do not complete this form and submit it with all required approvals prior to the enrichment experience, I will not have MSU liability insurance coverage during my clinical enrichment experience. I understand that I cannot participate in my clinical enrichment experience if I have already worked 80 hours in a week.

_____ _____ _____

Signature **Date** **Contact Phone Number**

2. APPROVAL OF SCHEDULED ROTATION HOSPITAL (REQUIRED):

By my signature, I acknowledge and grant permission for the above noted student to participate during his/her off duty times or weekends in the requested educational enrichment opportunity. I further acknowledge that participation in this enrichment will not interfere with commitments of his/her current rotation and the student will not exceed 80 hours between their scheduled rotation and clinical enrichment experience.

_____ _____ _____

Director of Medical Education (DME) **AND** **Supervising Physician** **Date**

(Signature not required unless participating in hospital)

3. APPROVAL OF ENRICHMENT HOSPITAL/CLINIC (REQUIRED):

By my signature, it is my understanding that participation in this educational enrichment opportunity will take place during off duty times or weekends when the above noted student is not committed to requirements of another scheduled rotation. I further understand that without approvals prior to participation the above noted student will not be covered under MSU liability. I understand that the student cannot participate in the clinical enrichment experience if they have already worked 80 hours.

_____ _____ _____

Director of Medical Education (DME) **AND** **Supervising Physician** **Date**

(Signature not required unless participating in hospital)

4. APPROVAL BY MSUCOM:

Without MSUCOM signature of approval, student will not be covered under MSU liability insurance.

_____ _____

MSUCOM Official Signatory **Date**

Return form to MSUCOM Office of the Registrar | Email: OsteoMedReg@hc.msu.edu | Fax: 517-432-1976 | Revised: 11/7/2018