



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? Is this your First Rotation with BayCare?

Did you obtain a Physician Sponsor? Did you complete the required training?

Did you export your Training Transcript to submit with the application? Does your school have a current Affiliation Agreement? (Verify w/school or call 727-519-1300.)

School Information

School Name

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

Phone Number Email

Student Type

What is your Student Type? MS/PG Year

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

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> BayCare Surgery Center-Trinity | <input type="checkbox"/> Morton Plant | <input type="checkbox"/> St. Joseph's – Children's | <input type="checkbox"/> Winter Haven Behavioral Health |
| <input type="checkbox"/> BayCare Medical Group | <input type="checkbox"/> Morton Plant North Bay | <input type="checkbox"/> St. Joseph's – North | <input type="checkbox"/> Urgent Care Center |
| <input type="checkbox"/> Bardmoor Surgery Center | <input type="checkbox"/> North Bay Recovery Center | <input type="checkbox"/> St. Joseph's – South | <input type="checkbox"/> Behavioral Health Outpatient |
| <input type="checkbox"/> Bartow Regional Medical Center | <input type="checkbox"/> Physician Surgery Center | <input type="checkbox"/> St. Joseph's – Women's | Location: _____ |
| <input type="checkbox"/> Carillon Surgery Center | <input type="checkbox"/> South Florida Baptist | <input type="checkbox"/> St. Joseph's Behavioral Health | <input type="checkbox"/> Behavioral Health Inpatient |
| <input type="checkbox"/> Mease Countryside | <input type="checkbox"/> St. Anthony's | <input type="checkbox"/> Winter Haven | Location: _____ |
| <input type="checkbox"/> Mease Dunedin | <input type="checkbox"/> St. Joseph's | | |

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: _____