CLINICAL AUTHORIZATION LETTER (CAL)

(For Visiting Student or Resident Clinical Rotations)

THIS DOCUMENT IS REQUIRED TO BE COMPLETED FOR ALL "FOR CREDIT" CLINICALS (Medical, Medical Assisting, Residency) – SUBJECT TO FINAL APPROVAL BY AMERICLERKSHIPS MEDICAL SOCIETY.

Updated: 11/17/2014 *** Indicates Required Fields**

AmeriClerkshipsMedicalSociety
AmeriClerkships.org
Top Applicants • Stronger Workforce • Improved Healthcare

IMPORTANT NOTES FOR STUDENT AND SPONSOR:

AMS is requesting information regarding the named visiting student/resident ("Student") clinical rotations/externships ("Clinicals") as well as the college/residency's ("Sponsor") requirements using this CAL form. The purpose of a CAL is to ensure that Students are conducting their visiting rotations in compliance with their Sponsor's policies. This CAL must be completed by both the Student and an official in charge of the Student's clinical rotations at the Sponsoring institution, **unless a Student waives his/her right to a Sponsor completed CAL** (below). Note that a completed CAL on its own does not constitute a formal agreement between AMS or the Sponsor or the Student, and the Student is subject to the AMS Enrollment Agreement. **Upon completion, please scan (in color) and email back to your Residency Enrollment Strategist.**

TO BE COMPLETED BY THE STUDENT: **Circle One***: Student Graduate Resident

Name of Student*: _____ **Date of Birth***: _____ **Tel Number***: _____

Email*: _____@_____ **Requesting to Start First Clinicals Block On***: ____/____/_____

Clinical rotation specialty, hours/week and total weeks being requested (not in any order of preference)*:

Clinical Block #1 Specialty: _____ _____ Hours/Week _____ Total Hours/Week
Clinical Block #2 Specialty: _____ _____ Hours/Week _____ Total Hours/Week
Clinical Block #3 Specialty: _____ _____ Hours/Week _____ Total Hours/Week
Clinical Block #4 Specialty: _____ _____ Hours/Week _____ Total Hours/Week
Clinical Block #5 Specialty: _____ _____ Hours/Week _____ Total Hours/Week
Clinical Block #6 Specialty: _____ _____ Hours/Week _____ Total Hours/Week
Clinical Block #7 Specialty: _____ _____ Hours/Week _____ Total Hours/Week
Clinical Block #8 Specialty: _____ _____ Hours/Week _____ Total Hours/Week
Clinical Block #9 Specialty: _____ _____ Hours/Week _____ Total Hours/Week
Clinical Block #10 Specialty: _____ _____ Hours/Week _____ Total Hours/Week

☐ **Optional:** I understand that I am waiving my right to have my Sponsor (medical school or residency) complete this Clinical Authorization Letter. By doing so, I will select and approve my clinical rotations through AmeriClerkships Medical Society (AMS) on my own, and I take full responsibility for gaining the approval of my school, any regulatory authorities (now or in the future), and any other body which may review my clinical experience for approval. As such I hold AMS and my Sponsor harmless in any event or circumstance which may arise from the clinical experiences described herein. (***If this option is selected, Student must place initials here: _____, then skip to the bottom of this page & sign under "Student"***).

TO BE COMPLETED BY THE SPONSOR:

Name of College/Residency*: _____ **WWW***: _____

Name of Official Completing this CAL*: _____ **Title***: _____

Email*: _____@_____ **Tel Number***: _____

1. Sponsor is listed in the International Medical Education Directory (https://imed.faimer.org/)*: ☐ No ☐ Yes

2. Sponsor is recognized by CA Med Board (www.mbc.ca.gov/Applicants/Medical_Schools/Schools_Recognized.aspx)*: ☐ No ☐ Yes

3. (US Colleges Only) Sponsor is approved by agency responsible for licensing of its postsecondary education*: ☐ No ☐ Yes: State: ____

4. Student is in good financial and academic standing with the Sponsor*: ☐ No ☐ Yes

5. Sponsor gives consent to the Student to complete his/her Clinicals through AMS affiliated Clinical Sites*: ☐ No ☐ Yes

6. Financially responsible party for all clinical blocks outlined above*: ☐ Student ☐ Sponsor ☐ Other: _____

8. Sponsor REQUIRES the following in order for the Student to receive credit for the above U.S. clinical rotations*:

☐ Utilize the Sponsor's clinical evaluation form (must attach)
☐ Utilize the Sponsor's clinical curriculum (must attach)
☐ Work with other students and residents where available
☐ Attend local residency or hospital grand rounds where available
☐ Perform weekly case presentations
☐ Be both inpatient and outpatient where available
☐ Have a rural outpatient component
☐ Other: _____

Selections below WILL require processing & cause significant delays:

☐ May utilize the Clinical Site's clinical curriculum (where available)
☐ Clinical Site's name must appears in ACGME.org or Osteopathic.org
☐ Student must be processed through hospital's Medical Staff Office or equivalent (for future verification only; Affiliation Agreement required)
☐ Pre-clinical documents that need processing (must attach)
☐ Government documents that need processing (must attach)
☐ Other: _____

SIGNATURES & SEALS:

Sponsor*

Signature: _____ Date: _____

Print Full Name: _____ Title: _____

OFFICIAL SEAL OF SPONSOR*

AmeriClerkships Medical Society*

Signature: _____ Date: _____

Print Full Name: _____ Title: _____

Student*

Signature: _____ Date: _____

Print Full Name: _____ Title: _____