CLINICAL INTERNSHIP/SHADOWING CHECK LIST: Prior to applying to graduate programs in any health care field, you should gain experience interning/shadowing with health professionals.

Due to privacy and liability concerns, most hospitals will have requirements you must fill prior to even shadowing with their physicians. Unless the shadowing is part of a course for credit at Wofford, the College is not involved in these arrangements; they are strictly between you and the hosting hospital or clinic.

For our clinical internships interim course, we have made arrangements with Spartanburg Regional and Mary Black to “certify” that students have met a certain set of requirements, listed below. If you’re arranging shadowing at these hospitals on your own, you can get a head start by working through this list. Have all documentation sent to Dr. Moeller or Dr. Moss at Wofford, either by mail, fax, or email.

Dr. Moeller’ email:  moellerjf@wofford.edu  Dr. Moss’ email:  mossre@wofford.edu
Bio dept fax:  864-597-4629

We will keep all documentation on file in the biology department, for when you need it forwarded to clinicians or hospitals.

Other than providing the documents listed below at your request, Wofford cannot provide “contracts” or “certifications” for your clinical experiences.

Documentation required by Spartanburg hospitals:

1. _____Criminal Background Check: We use Surveillance, Resources & Investigations in Greenville: 864-232-4140. The cost will be approximately $35-$40 [included in the clinical internships interim costs]

2. _____PPD Skin Test (2 step), within the previous 12 months. You can get this at Student Health, or the Department of Health, or your doctor’s office. You’ll need to request documentation of your negative test, sent to Dr. Moeller or Dr. Moss.

3. ___Evidence of Measles & Rubella immunity: Your parents might have a vaccination record for you; otherwise your physician will have one for you.

4. ___Evidence of Chicken Pox immunity; or a “reliable oral history”: if your parents are certain that you’ve had chicken pox, that will be fine.

5. ___Evidence of Hepatitis B vaccination

6. ___Evidence of flu vaccine for the current year

7. ___Negative Pre-employment Drug Screening.
   We have used:
   - Matthew Johnson  
   WorkWell Occupational Health  
   135 Commonwealth Drive, Suite 250  
   Greenville, SC 29615  
   Phone: 864.675.4695

8. ___Hospital orientation: You’ll have to satisfy the orientation requirements for the relevant hospital. Once you have satisfied steps 1-6 above, Dr. Moeller or Dr. Moss will contact Gloria Graves at SRMC for you, to arrange for an orientation.
AUTHORIZATION FOR RELEASE OF INFORMATION FOR INVESTIGATIVE CONSUMER REPORT

PRIVACY ACT STATEMENT
In compliance with the Privacy Act of 1974, the following information is provided: Basic authority for collecting the requested information is contained in E.O. 12450:5 USC 1303-1305; 42 USC 2165 and 2455: 22 USC 2585 and 2519: and 5 USC 3301. This form will be furnished to individuals and organizations for the purpose of obtaining information from them about you and your activities in connection with an official background investigation concerning: (1) fitness for employment, (2) clearance to academic program, (3) security clearance or access to sensitive materials, or (4) any other legitimate purpose within the scope of employment responsibilities. Furnishing the requested information is voluntary, but failure to provide all or part of the information may result in a lack of further consideration for enrollment, clearance or access, or in the termination of your academic enrollment.

Name of College: __________________________  Program/Department: __________________________

In relation to my academic enrollment/participation, I authorize Surveillance, Resources and Investigations, LLC (SR&I, LLC) to construct an investigative consumer report with information pertaining to my background, reputation or disposition, including, but certainly not limited to, facts involving my employment, education, social security number, authentication, driving record, consumer credit history, criminal record history and/or additional public records history. I authorize all parties to release all information applicable to this investigation. I release from liability all persons, governmental agencies, as well as other companies and agencies disclosing any and all information. In addition, I authorize that photocopies of this form may be considered as an original.

Print Last Name  First Name  Middle Name  Maiden/other

HAVE YOU EVER BEEN CONVICTED OF A CRIME OTHER THAN MINOR TRAFFIC VIOLATION? __________

IF YES, LIST STATES __________

D.O.B / GENDER M OR F (CIRCLE ONE) __________
Social Security # __________
Driver’s License # __________
DL State __________

Current Street Address __________
From Date __________
To Date __________

City __________
State __________
Zip __________
County of Residence __________

HAVE YOU RESIDED WITHIN SOUTH CAROLINA FOR 12 MONTHS? YES / NO

HAVE YOU RESIDED WITHIN TWO DIFFERENT STATES WITHIN THE LAST 12 MONTHS? YES / NO

HAVE YOU WORKED WITHIN TWO DIFFERENT STATES WITHIN THE LAST 12 MONTHS? YES / NO

IF YES, LIST STATES: __________

Prior Addresses for Past Ten Years (attach additional pages if need)

City __________
State __________
County __________
Dates: From __________
To __________

City __________
State __________
County __________
Dates: From __________
To __________

I have read, comprehended and authorize, any person, company or other entity contacted by Surveillance, Resources and Investigations, LLC (SR&I, LLC), to provide the information stated above.

SIGNATURE- __________________________  DATE- __________

MAIL TO:
SR&I P.O. BOX 5106 GREENVILLE, SC 29606