South Pointe Hospital
a Cleveland Clinic hospital

Graduate Medical Education

Medical Student Badge/Medical Record Access Form

Name:_____ **Sex:**_____

DOB: ____/____/____ **Badge number:** _____ / _____

School:_____ **SS#:**_____

Dates **Rotation**

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By signing this form, you are accepting full responsibility for the use and care of your badge.

It is your responsibility to return your badge to the GME department at the end of each rotation. GME Staff will show you where to return the badge.

_____ _____

Signature Date