



Application for Rotation – Visiting Resident

SECTION I: To be completed by the Visiting Resident

Last Name: _____ First Name: _____ Middle Initial: _____

Email address: _____

Contact Phone Number: _____ Mobile _____ Home _____

I have a pager that will work in Grand Rapids _____ Number: _____

Please use my mobile number in lieu of a pager for clinician communications and call schedules

*Mobile number must be listed above and will be used to create resident/fellow PerfectServe profile and shared with faculty/staff as needed

NPI Number: _____ Do you have a Federal DEA? Yes No

Date of Birth: _____ US Social Security Number: _____

*Required for IRIS reporting

Sponsoring Hospital or Institution: _____

Current Residency/Fellowship Program: _____ Current PG Year: _____

Program Director or Coordinator/Administrator: _____

Coordinator Email: _____ Phone: _____

ROTATION REQUEST(S)

Dates

1st Choice _____ TO _____

2nd Choice _____ TO _____

3rd Choice _____ TO _____

<u>Office Use Only</u>	
Approved _____	Date Coming _____
Type of Learner _____	Visiting Resident/Fellow _____
Application Received _____	
Application Processed _____	

Visiting Resident Application Checklist

I understand submission of an application does not constitute approval of rotation request.

I have attached copies of all required documentation, including but not limited to:

- Current Educational Limited or Permanent Medical and Controlled Substance Licenses (*Michigan licenses are required for all resident clinical rotations and fees for non-Spectrum Health employees are the responsibility of the resident/fellow*)
- ERAS Application
- ECFMG Certificate (*if international medical school graduate*)
- Medical School Diploma
- Certificate of Professional Liability Insurance which will provide coverage while rotating with Spectrum Health - minimum \$1m occurrence and \$3m annual aggregate coverage (*Spectrum Health does not provide liability coverage for visiting residents*)
- ACLS Certificate
- NRP and/or PALS Certificates (*if requesting inpatient pediatric rotation*)
- ATLS Certificate (*if requesting trauma rotation*)
- Rotational Goals and Objectives

I will pay the \$100 per rotation fee(s) and non-refundable application fee (if applicable) online at www.onlineregistrationcenter.com/resident

(OR)

My program/institution will pay the \$100 per-rotation fee(s) and non-refundable application fee (if applicable)

**\$125 application fee applies if home institution does not confirm completion of Spectrum Health background check and drug screen requirements outlined in Section II of this application*

If accepted for a rotation at Spectrum Health, the Resident agrees to the following:

- Resident will complete any required institutional and rotation-specific orientations
- Resident will comply with all Spectrum Health and specific training site policies
- Resident will perform assigned duties to the best of his/her ability
- Resident will provide his/her own housing and transportation
- Resident will maintain patient confidentiality by following all HIPAA regulations

Residents/fellows from institutions which do not have a current affiliation agreement with Spectrum Health must submit completed application **no less than 90 days in advance of rotation start date**. The deadline for residents/fellows whose programs do have a current affiliation agreement is no less than **60 days in advance of rotation start date**. Applications should be submitted via email to:

Sidra.Alexander@spectrumhealth.org or mail to Office of Research & Education, 945 Ottawa Ave NW, Grand Rapids, MI 49503.

I authorize my Program Director to release to Spectrum Health Office of Medical Education all performance and health information necessary to complete SECTION II of this application.

Applicant's Signature

Date

SECTION II - To be completed by Resident’s Program Director or Coordinator/Administrator

Please provide the following information regarding

Printed Resident’s Name

YES NO The above-named resident is currently in good standing.

YES NO The above-named resident has the required academic background and skills necessary to participate in and is approved to take the requested rotation.

If there have been any academic/clinical performance, liability, disciplinary, or other problems with this Resident, please explain:

YES NO The above-named resident has completed training regarding HIPAA and hazardous materials, universal bodily fluid precautions, exposure to blood borne pathogens, and such other federal, state, and local laws and regulations relating to patient care in a hospital setting.

agrees to provide professional liability coverage for the

Name of Sponsoring Institution

above-named resident during his/her rotation at Spectrum Health.

OR

Resident/Fellow will self-obtain required liability insurance coverage for duration of rotation(s) at Spectrum Health.

Please confirm that upon entry to your program and/or employment by your institution, above-named Resident or Fellow Physician satisfactorily completed the following. If not confirmed, Spectrum Health will process a background check and/or drug screen and resident or institution will be charged an application fee.

YES NO At minimum, 5-panel drug screening

YES NO Thorough background investigation including the following elements – National & Global Criminal Search (government source or media source), SSN Trace, Professional License Report, Health Care Sanctions (All), MVR, and National Sex Offender Registry

I agree to all of the preceding terms and affirm that all submitted information is correct:

Program Director’s Signature (or designee)

Date

Printed Name