

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: _____
(Required for rotations)

I need a loaner pager for my rotation at Spectrum Health _____

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

Date of Birth: _____ US Social Security Number: _____

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 <u>Visiting Resident/Fellow</u>	
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
- 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 (*Spectrum Health does not provide liability coverage for visiting residents*)
- Proof of Blood Borne Pathogen, Universal Precautions, and HIPAA Training (*Completed Section II with program director signature accepted in lieu of individual copies*)
- 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 non-refundable application/rotation fee(s) online at www.onlineregistrationcenter.com/resident and submit proof of payment to Sidra.Tees@spectrumhealth.org
(OR)

My program/institution will pay my application and rotation fee(s)
(*\$225 application/first rotation fee; \$100 for each subsequent rotation during residency/fellowship tenure*)

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

Submit completed application **no less than 90 days in advance of rotation start date** via email to: Sidra.Tees@spectrumhealth.org or mail to Office of Medical 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:

The above-named resident completed Blood Borne Pathogen Training on _____, *Date*

Universal Precautions Training on _____, *Date*, and HIPAA training on _____, *Date*.

Name of Sponsoring Institution agrees to provide professional liability coverage for the above-named resident during his/her rotation at Spectrum Health.

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

Program Director's Signature

Date

Printed Name