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ROTATING RESIDENT/FELLOW APPLICATION

☐ M.D.

Name: _____ ☐ D.O. Today's Date: _____

Local Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Pager: _____

E-mail: _____

Date of Birth: _____ Place of Birth: _____

SSN: _____ Citizenship: _____ ☐ Male ☐ Female

Emergency Contact: _____ Relationship: _____ Phone: _____

Base Hospital: _____ Base Program Director: _____

Base Program: _____ Level of Training (PGY): 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐

(As of rotation date)

Base Program Coordinator: _____ PC's Phone: _____

PC's E-mail: _____ PC's Fax: _____

Medical School: _____ Location: _____

Start Date (Mo/Yr): _____ Graduation Date (from Diploma): _____

ECFMG # (If Applicable): _____ Date Taken: _____

Work History: (fully describe any time (6 months & over) between medical school graduation date and start of current residency program, i.e. prior residency program, travel, private practice, family obligations, etc. Please give exact dates. (Use additional page if more space is required.)

_____

_____

_____

_____

AZ Medical/Osteopathic Permit/License:
(Attach a copy of your registration card or Med Board Verification of Number)

☐ Postgraduate Permit

☐ License to Practice

Registration/License #: _____ Expires: _____

Have you ever been charged with a violation of any statute of state, the U.S. or any foreign country? ☐ Yes ☐ No

If yes, please provide a statement (Use additional page if more space is required):

_____

_____

NOTE: In compliance with Arizona State Public Health laws it is mandatory that all personnel provide evidence of immunity to TB, Rubella, Rubeola, Hepatitis B and Varicella before reporting to assigned duties. Verification of immunization form is required.

I hereby certify that the information I submit in this application is complete and correct to the best of my knowledge and belief.

_____ _____

Applicant's Signature Date

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ROTATING RESIDENT/FELLOW APPLICATION PAGE 2

Name: _____ ☐ M.D. ☐ D.O.

Pager: _____ E-mail: _____ PGY Level: _____
(at the time of rotation)

Base Hospital: _____

Base Program Coordinator: _____ Phone: _____

Rotating Hospital: _____

Rotating in the Department of: _____ Name of Rotation: _____

1st Rotation Start Date: _____ Rotation End Date: _____

2nd Rotation Start Date: _____ Rotation End Date: _____

Previous Rotations at Rotating Hospital: ☐ Yes ☐ No

ACLS: ☐ Yes ☐ No Expiration Date: _____ ATLS: ☐ Yes ☐ No Expiration Date: _____

DEA #: _____ NPI #: _____

Current Residency/Fellowship:

Specialty	Name and Location of Program	Beginning	Projected End

Residency History: First Residency (including preliminary or transitional):

Specialty	Name and Location of Program	Beginning	Ending

Subsequent Residencies (before current program) if applicable:

Specialty	Name and Location of Program	Beginning	Ending

Requested Vacation Dates (Dates requested are not guaranteed unless approved by the Department Program Coordinator)

1st choice: _____ 2nd choice: _____ 3rd choice: _____

_____ / /
Base Program Director Signature Date

Check List
- ❑ Universal Application
- ❑ Verification of Residency Information
- ❑ Verification of Immunizations
- ❑ CV
- ❑ Certificates (Medical School and Residency)
- ❑ ECFMG (if applicable)
- ❑ AMB/OBEX License
- ❑ Resident/Fellow Competency Form

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_____ _____
Program Director Signature Date

_____ _____
Approved by GME Committee Date

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VERIFICATION OF IMMUNIZATIONS

Name: _____

SSN: _____ Date of Birth: _____

Base Hospital: _____

Base Program: _____

APPLICATION REQUIREMENTS:

For the protection of patients, residents, fellows, faculty, and employees, rotating residents/fellows must document the following before their rotations:

* Tuberculin test in the past twelve months
* Varicella, rubella, and rubeola immunity
* Up-to-date diphtheria and tetanus shots
* Hepatitis-B vaccination or signed declination

TUBERCULIN TEST

* Negative TB Test Date: _____

OR

* Negative Chest X-ray Date: _____

MEASLES, MUMPS & RUBELLA

* Two immunizations after 12 months of age

Dates: _____ _____

☐ Documentation of disease by physician OR ☐ Titer results indicating immunity

HEPATITIS-B

* Vaccine series completed Date: _____

OR

☐ Signed declination

TETANUS/DIPHTHERIA

* Vaccination Date: _____

VARICELLA

Have you had Chicken Pox? ☐ Yes ☐ No

* Vaccination Date: _____

☐ Titer results indicating immunity (PCH REQUIRES TITERS) DATE:

This form must be signed by the Base Hospital's Program Coordinator.

_____ _____

Signature Date

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VERIFICATION OF PROGRAM INFORMATION

Name: _____

Last 4 # of SSN: _____ Date of Birth: _____

Base Hospital: _____

Base Program: _____

RESIDENCY/FELLOWSHIP INFORMATION:

To be completed by official from applicant's residency/fellowship program

☐ Yes ☐ No The above named resident/fellow is in good academic standing.

☐ Yes ☐ No The above named resident/fellow has completed his/her USMLE/COMLEX exams with the following scores:

Test 1_____ Test 2_____ Test 2 CS_____ Test 3_____

☐ Yes ☐ No Resident/fellow malpractice/liability insurance is provided by the home institution for the resident/fellow while away from the residency/fellowship program.

☐ Yes ☐ No Personal health coverage is provided by the home institution for the resident/fellow while rotating. (If no, the resident/fellow must provide proof of coverage with application.)

☐ Yes ☐ No The resident/fellow has completed a training program in universal precautions ensuring the appropriate handling of blood, tissues and body fluids.

☐ Yes ☐ No The resident/fellow has compliance completed training for Health Insurance Portability and Accountability Act (HIPAA).

☐ Yes ☐ No The resident/fellow has completed and passed a background check at his/her home institution.

Name of official completing this document:

Printed Name _____ Title _____

Signature _____ Date _____

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