

## Application for Visiting Residents and Fellows

**Ascension Genesys Hospital**  
**Medical Education Department**  
One Genesys Pkwy, Suite 2620  
Grand Blanc, MI 48439  
(810) 606-5980  
<https://genesysmeded.com/>

We appreciate your interest in a rotation at Ascension Genesys Hospital. Prior to completing this application, you must contact the Program Manager to confirm that the rotation is available. The application and the supporting documents must be submitted to the Medical Education Department at least 60 days prior to your requested rotation start date. A rotation is approved upon receipt of the application and all supporting documents. We must receive written notification 30 days in advance if a rotation needs to be cancelled.

The Program Manager will provide you with access to New Innovations to upload the following documents:

- Visiting Intern/Resident/Fellow Application
- A fully executed Affiliation Agreement
- A current Curriculum Vitae
- A copy of a valid Medical License, Controlled Substance License, and Federal DEA (if applicable)
- A copy of Medical School Diploma
- Proof of Professional Liability Insurance Coverage
- A letter of recommendation from your residency Program Director, which identifies your current status in the program and evaluates your progress thus far.
- A copy of the letter from the accreditation agency (ACGME) verifying your current program's status.
- A copy of your rotation schedule from your training program that specifically states the name of rotation at Genesys, the exact dates of the rotation, and the name of the hospital you are currently affiliated with, signed by your Program Director.
- A copy of current ACLS and BLS certification
- A copy of current immunizations including TB record. Please note your TB must be CURRENT for the entire length of the rotation.
- A copy of current influenza annual vaccination. Please note your influenza annual vaccination must be administered within the current academic year.
- A copy of ECFMG certificate (if applicable)
- A copy of your COVID-19 vaccination card.



### Application for Visiting Residents and Fellows

Applicant Name: \_\_\_\_\_ SS#: \_\_\_\_\_ D.O.B. \_\_\_\_\_ NPI# \_\_\_\_\_

Home Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Email: \_\_\_\_\_

Medical School: \_\_\_\_\_ Grad Mth/Yr: \_\_\_\_\_

Current Program: \_\_\_\_\_ Current PGY Level: \_\_\_\_\_

Start and End Date of Current Program: \_\_\_\_\_ DEA #: \_\_\_\_\_

Have you completed training in any other program prior to your current program? Yes No  
If yes, please indicate Program Name, Location, and Dates  
\_\_\_\_\_

Name of Home Institution: \_\_\_\_\_

Home Institution Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Contact Person at Home Institution: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Rotation Requested: \_\_\_\_\_ Supervising Attending: \_\_\_\_\_

**Exact** Dates of Rotation: \_\_\_\_/\_\_\_\_/\_\_\_\_ TO \_\_\_\_/\_\_\_\_/\_\_\_\_

Is Housing Needed: Yes \_\_\_\_\_ No \_\_\_\_\_

I hereby verify that the information and documents contained in this application are accurate, authentic and complete. I, as "Resident" agree to:

- 1.) Perform duties satisfactorily and to the best of my ability under the Medical Education Authority of the Hospital.
- 2.) Conform to all Hospital Policies, Procedures and Guidelines, including Medical Staff Rules and Regulations that are not inconsistent with this policy. (These can be reviewed in the Office of Medical Education).
- 3.) Arrange for housing and all other financial obligations through my home program and personal means. Ascension Genesys Hospital assumes no financial obligations for housing, stipend, insurance or other benefits.
- 4.) Fulfill all responsibilities and assignments defined by the Chief Instructor of the educational experience.
- 5.) Complete all medical records for which I am responsible in a timely manner and in full compliance with all policies and/or requirements established by the Hospital and/or Medical Staff and/or Attending Physician(s). I am aware that failure to complete all medical records responsibilities may result in a failed rotation.
- 6.) Unless authorized by the program director or specified in contractual relationships with the visiting trainee's hospital, vacation and conference requests shall not be authorized during the rotation.
- 7.) Upon completion of the rotation, visiting trainee will be required to check out of AGH by completing a clearance form in Medical Education. Failure to properly check out may result in an incomplete rotation.

**Signature of Applicant:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## PART II – To be completed by Home Institution

I Verify That....

- The above-named Resident/Fellow is a trainee in good standing in a program that I direct.
- The above-named Resident/Fellow has received all Hazardous Materials training and Universal Body Fluid exposure to blood borne pathogens training as required by State of Michigan and Federal Law.
- Ascension Genesys Hospital will assume no financial responsibilities (e.g. stipend, benefits, housing, etc) for this trainee.
- The above-named Resident/Fellow will be adequately covered by Professional Liability Insurance for activities to be performed at Ascension Genesys Hospital under a policy issued to the home institution and program by:

Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Limit per incident \$ \_\_\_\_\_ Limit per aggregate \$ \_\_\_\_\_ Policy Expiration: \_\_\_\_\_

I acknowledge that Ascension Genesys Hospital will claim the above named Resident/ Fellow's time via I.R.I.S. Please estimate the percentage of time the above-named Resident/Fellow will spend during the requested rotation.

Initial Residency Code: \_\_\_\_\_

Ascension Genesys Hospital \_\_\_\_\_% Non-Hospital Clinic Setting \_\_\_\_\_%

Other Hospital (s) \_\_\_\_\_% Hospital: \_\_\_\_\_%  
Name Name

**Signature of Home Institution Program Director** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Home Institution DME:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## PART III – To Be Completed by Ascension Genesys Hospital

Documents Received:

CV \_\_\_\_\_ Med License/DEA \_\_\_\_\_ Diploma \_\_\_\_\_ Malpract Info \_\_\_\_\_ Ltr of Rec \_\_\_\_\_ Rotation  
 Schedule \_\_\_\_\_ Program Accred Letter \_\_\_\_\_ ACLS/BLS \_\_\_\_\_  
 Immunizations/TB \_\_\_\_\_ Flu \_\_\_\_\_ COVID \_\_\_\_\_ ECFMG (if applicable) \_\_\_\_\_  
 Affiliation Agreement \_\_\_\_\_ Housing Scheduled and Fee Recvd \_\_\_\_\_

The above rotation has been approved:

**Signature of DME:** \_\_\_\_\_ **Date:** \_\_\_\_\_