Visiting House Officer Application for Clinical Rotation

Section I: To be completed by the Applicant (print or type).

HFWH Rotation/Service Requested: _____

Length of Rotation (provide exact dates) From: _____ **To:** _____

Last Name: _____ First Name: _____

Circle one each: M.D. or D.O. Male or Female Date of Birth: _____

Social Security Number: _____ Non-US Citizens: ☐ J-1 Visa ☐ H1B Visa

Email Address: _____

Cell Phone # _____ PGY: _____ ☐ Resident ☐ Fellow

Medical School: _____ Year Graduated: _____

DEA Number: _____ NPI Number: _____

Home Institution Name, City, State: _____

Your current residency or fellowship program: _____

Name, email, & phone for <u>your</u> program coordinator: _____

Any time away from rotation (e.g., continuity clinics): _____

Hours/week: _____ If less than 40 hrs., how time will be used: _____

☐ Epic, describe your training/experience: _____

Your application is not complete unless <u>all</u> the following are attached (check those attached):

- ☐ Up-to-date CV, including all post-graduate training; list current program first
- ☐ Copy of Medical School Diploma
- ☐ Copy of Medical License (IF licensed in another state and rotation is less than 31 days, attach copy of out-of state license; if HFHS rotation is 31 or more days apply for MI License
- ☐ Copy of ECFMG Certificate, if Foreign Medical Graduate
- ☐ Copy of DEA, if Full Michigan Medical License; not required for Educational License Copy of Michigan Controlled Substance License
- ☐ Infection Control Documentation (Proof of current TB immunization, Flu Vaccine required December through May)
- ☐ ACLS (required for all rotations, PALS is an acceptable replacement for ACLS **for Peds rotations** only)
- ☐ BLS (required for all rotations, PALS acceptable replacement for BLS **for all rotations**)

House Officer Signature: _____ Date: _____

Submit completed form, including required attachments, to your Program Director for approval.

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If you have questions, please contact Jackie O'Connor at 734-287-9030 or joconno6@hfhs.org

Last Name:_____ First Name:_____

Section II: To be completed by the Applicant's Program Director

- The house officer is not under any disciplinary restrictions at this time.
- I approve the above rotation.
- The house officer will continue to be paid by our institution during this HFHS rotation.
- Professional liability coverage will be provided by HFHS during this rotation.

☐ **Program Letter of Agreement (PLA) if required by the Sponsoring Institution (attach).**

Program Director (print): _____

Department/Service: _____

Email: _____

Phone number:_____ Fax number: _____

Program Director's Signature:_____ Date:_____

Return completed form, including all required attachments, to Medical Education

Section III: To be completed by HFWH Medical Education

- I approve the above rotation through my service.
- Professional liability coverage will be provided by HFHS during this rotation.

☐ **Visiting house officer is to observe only (e.g., no patient contact).**

☐ If **PLA required by Sponsoring Institution; must be reviewed and signed by DME (attach).**

☐ **Rotation requires Epic training (check all required)** Inpatient

☐ Provider

☐ Ambulatory ☐ ASAP for ED ☐ Anesthesia Provider

Approving HFHS Program Director: _____

Supervising Physician Signature:_____ Date:_____

Submit completed form, including all required attachments, to Medical Education