 **Graduate Medical Education**

**VISITING RESIDENT/FELLOW ROTATION APPLICATION**

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| **APPLICANT INFORMATION**  | FIRST AHO ROTATION/NEED ORIENTATION RETURNING ROTATION |
| Last Name:  | First Name:  |  | M.I.:  | Date:  |
| Gender  |  F M  | Date of Birth:  | SSN: | NPI: TRN/ME: |  |
| School Issued Email Address:  |  | Primary Phone:  |  |
| Emergency Contact Name:  |  | Emergency Contact Phone:  |  |
| Have you been a student or employed at AdventHealth? |  | AdventHealth Employee OPID: |  |

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| **SCHOOL/PROGRAM CONTACT INFORMATION** (OFFICIAL DESIGNATED TO RECEIVE CORESPONDENCE/AFFILIATION AGREEMENT/EVALUATION)  |
| School/Program Name:  | Expected Graduation Date (mm/yy):  |
| Coordinator First Name:  | Coordinator Last Name:  |
| Title:  | Email:  |
| Street Address:  |  City: State: Zip  |
| Business Phone:  | Business Fax:  |
| **ROTATION REQUEST** (One request per application.) Inpatient Experience Outpatient Experience  |
| Preceptor Name (*First & Last*): Credentials:  |
| Specialty/Department:  | Rotation Start Date:  | End Date:  |
| **RESEARCH:** Research is considered an extracurricular activity unless part of the academic affiliation agreement during a clinical rotation.  |
|  I do intend to participate in research while on rotation  |  I do not intend to participate in research while on rotation  |
| **TRAINING STATEMENT**  |
| Are you aware of any limitations that would prevent you from performing the duties required for the training you are requesting? Yes, Please Explain: No  |
| **DISCLAIMER AND SIGNATURE**  |
| I certify that my answers are true and complete to the best of my knowledge. If this application is approved, I understand that I am responsible for submitting all required documents, as indicated in this application, including any additional documents as requested by the AdventHealth Orlando GME Office. I agree to obtain prior written approval of AdventHealth before publishing any material related to the learning experience provided.  |
| Applicant Signature  | Date  |

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| VISITING RESIDENT/FELLOW - CLINICAL INPATIENT HOSPITAL ROTATION APPLICATION Page 2  |
| Applicant Name: |  | Start Date: | End Date: |  |
| Program Name: |  |
| preceptor statement (MUST BE COMPLETED TO PROCESS THIS APPLICATION) |
| I am a Physician with an unrestricted license to practice in my specialty, and current member of the AdventHealth Orlando Medical Staff. I have professional liability coverage in the amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000. By my signature below, I agree to precept the medical student in a clinical rotation. I agree to allow the medical student named above to complete the rotation dates requested on this application. I assume full responsibility for the education, evaluation, conduct and actions of the trainee while on rotation, credentialed to practice at AdventHealth Orlando System. I have a valid affiliation agreement with the designated academic institution. I am approved to precept students from this program. I agree to allow the student to complete the requested rotation(s). I assume full responsibility for the conduct and actions of the student while on rotation.I understand that any false or misleading statement made on my application may be grounds for denial of this application. I hereby certify that the foregoing information is true and correct. |
| Last Name: | First Name: | M.I. | Credentials: |
| Street Address: | City: | State: | Zip: |
| Hospital Name: | Service/Dept.: |
| Business Phone: | Business Fax: |
| Mobile:  | Email:  |
| Supervising Physician Preceptor Signature: Date: |
| required DOCUMENTatION to be submitted to New innovations after preceptor approval |
| [ ]  Complete Application with Preceptor Approval Signature[ ]  ESPAA Form – Computer Access Agreement Signed by Applicant | [ ]  PROOF OF MALPRACTICE LIABILITY INSURANCE**\*** |
| [ ]  LETTER OF GOOD STANDING from your School/Program | [ ]  LEVEL 1 BACKGROUND SECURITY CHECK**\***  |
| [ ]  5-Panel Drug Screen (Amphetamines, Marijuana, Cocaine, Opiates, and Phencyclidine)\* Negative and Valid if completed while enrolled in current program  | [ ]  TUBERCULOSIS SCREENING (PPD, Quantiferon or Clear Chest X-ray) **Date:**  |
| [ ]  COPY OF PHOTO ID/Student ID and Copy of Health Insurance\* or Card  | [ ]  RESPIRATORY MASK FIT CERTIFICATE **Date:** |
| [ ]  ALN CBL Transcript - After completing online training[ ]  HR Packet – After orientation with Heather[ ]  COVID-19 Attestation Form – Due on first day of rotation | [ ]  PROOF OF IMMUNIZATIONS\* - MMR Vaccination - Varicella Vaccination or Immunity and Hepatitis B (If refused, you must provide a signed wavier) [ ]  Flu shot required Dec-March (If refused must wear mask in all patient care areas.) **Date of Flu Shot:** |
| **\*THESE DOCUMENTS CAN BE COMPILED IN THE LETTER OF GOOD STANDING OR A LETTER OF ATTESTATION – if included in the letter, originals are not required.** |

**Submit Documentation to:**  AdventHealth Orlando Graduate Medical Education

 Heather M.S. Hernandez, Medical Student Clerkship Coordinator

Heather.Hernandez@AdventHealth.com