 **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