



**APPLICATION (A)**

**FOR VISITING RESIDENTS  
PROVIDENCE HOSPITAL AND MEDICAL CENTERS**

Residents who desire to observe or participate in-patient care for educational purposes at Providence Hospital must complete the application below. All visiting residents must be sponsored and approved by a Residency Program Director, Chairman, or Section Chief at Providence Hospital. It is the responsibility of the visiting resident or his/her Medical Education department to complete this application in its entirety and obtain all signatures and sponsorship needed. The term resident as used below means resident or fellow. An original signed application must be submitted at least eight (8) weeks prior to start of rotation accompanied with proof of malpractice insurance (if applicable), documentation of a TB test within the past year, a copy of your current medical & pharmacy licenses, a copy of your ECFMG Certificate (if applicable), a copy of your Medical School Diploma (translated if in a foreign language) and a current CV. Failure to adhere to the guidelines as mentioned above and submission of required documentation will result in the denial of this rotation request.

**Section I: To be Completed by the Visiting Resident Applicant**

Applicant's Name \_\_\_\_\_

Credentials: \_\_\_\_\_MD \_\_\_\_\_DO \_\_\_\_\_DDS \_\_\_\_\_DPM

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Medical School \_\_\_\_\_ Date Graduated \_\_\_\_\_

**Current Residency/Fellowship Name** \_\_\_\_\_

\_\_\_\_\_Allopathic (MD) \_\_\_\_\_ Osteopathic (DO) \_\_\_\_\_ Podiatric \_\_\_\_\_ Dental

Current PGY Status \_\_\_\_\_ Total all PGY Years of Training \_\_\_\_\_

Residency/Fellowship Director \_\_\_\_\_ Phone \_\_\_\_\_

Residency/Fellowship Institutional Sponsor (**Hospital**) \_\_\_\_\_

Current Home Address \_\_\_\_\_

Home Phone Number \_\_\_\_\_ Pager Number \_\_\_\_\_

Email Address \_\_\_\_\_

Fax Number for approval/disapproval notification: \_\_\_\_\_

Please indicate Providence rotation request details:

Rotation	Start Date	End Date	Hours/Days Not at Providence

**Section 2: To be completed by the Department Head at the Home Institution**

I approve the above rotation and verify that this resident will continue to be paid during his/her rotation at Providence Hospital and I further verify that malpractice insurance (unless otherwise by written agreement) will be provided by our institution and will cover his/her activities at Providence Hospital. I understand and agree that time spent at Providence Hospital by the above resident will be reported by Providence Hospital on its IRIS report to claim Medicare GME Payments.

Print Name of Department Head \_\_\_\_\_

Title \_\_\_\_\_ Phone \_\_\_\_\_

Signature of Department Head \_\_\_\_\_ Date \_\_\_\_\_

**Section 3: To be completed by the Providence Hospital Residency Program Director/Chairman/Section Chief (Visiting Resident or his/her Medical Education Department must obtain all required signatures)**

I approve the application of the above named resident to serve as a visiting resident for educational purposes for the period specified above. The visiting resident will serve in the category checked below:

\_\_\_\_\_ Observer of patient care only

\_\_\_\_\_ Participate in patient care under the supervision of Providence Hospital faculty

Print Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Section 4: To be completed by Providence Hospital Medical Education Department**

TB Test \_\_\_\_\_ CV \_\_\_\_\_ Diploma \_\_\_\_\_ ECFMG \_\_\_\_\_ Malpractice \_\_\_\_\_ Med/Pharm Lic. \_\_\_\_\_

Medical Education Approval \_\_\_\_\_ Date \_\_\_\_\_

Inquires regarding this application should be directed to **Providence Hospital and Medical Centers, Department of Medical Education, 16001 West Nine Mile Road, Southfield, Michigan 48075, Phone: 248-849-3216.**



**APPLICATION (B)**

**FOR RESIDENTS REQUESTING “ADDITIONAL”  
ROTATIONS AT PROVIDENCE HOSPITAL AND MEDICAL CENTERS**

This application is to be completed by “only” those residents requesting additional rotation(s) at Providence Hospital, who have previously completed the initial Application for Visiting Residents, during **this current** academic year. No additional forms are needed. This will avoid duplication.

**Section I: To be Completed by the Visiting Resident Applicant**

Applicant’s Name \_\_\_\_\_

Credentials: \_\_\_\_\_MD      \_\_\_\_\_DO      \_\_\_\_\_DDS      \_\_\_\_\_DPM

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Please indicate Providence rotation request details:**

Rotation	Start Date	End Date	Hours/Days Not at Providence

**Section 2: To be completed by the Department Head at the Home Institution**

I approve the above rotation and verify that this resident will continue to be paid during his/her rotation at Providence Hospital and I further verify that malpractice insurance (unless otherwise by written agreement) will be provided by our institution and will cover his/her activities at Providence Hospital. I understand and agree that time spent at Providence Hospital by the above resident will be reported by Providence Hospital on its IRIS report to claim Medicare GME Payments.

Print Name of Department Head \_\_\_\_\_

Title \_\_\_\_\_ Phone \_\_\_\_\_

Signature of Department Head \_\_\_\_\_ Date \_\_\_\_\_

**Section 3: To be completed by the Providence Hospital Residency Program Director/Chairman/Section Chief (Visiting Resident or his/her Medical Education Department must obtain all required signatures)**

I approve the application of the above named resident to serve as a visiting resident for educational purposes for the period specified above. The visiting resident will serve in the category checked below:

Observer of patient care only

Participate in patient care under the supervision of Providence Hospital faculty

Print Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Section 4: To be completed by Providence Hospital Medical Education Department**

Medical Education Approval \_\_\_\_\_ Date \_\_\_\_\_

**AN IMPORTANT NOTE TO THE VISITING RESIDENT. IF THE FOLLOWING DOCUMENTS SUBMITTED WITH YOUR "INITIAL" APPLICATION REMAIN CURRENT FOR THIS NEW ROTATION REQUEST, THEN NO FURTHER DOCUMENTS ARE REQUIRED.**

- TB TEST
- DIPLOMA
- MALPRACTICE
- MEDICAL & PHARMACY LICENSES

***Prior to submitting this rotation request, it is your responsibility to confirm their continued validity. Non-compliant applications will be returned to your program coordinator.***

Inquires regarding this application should be directed to **Providence Hospital and Medical Centers, Department of Medical Education, 16001 West Nine Mile Road, Southfield, Michigan 48075, Phone: 248-849-3216.**

**Providence Hospital & Medical Centers  
 Medical Education Department  
 Professional History**

The following information is required to insure the accuracy of our records and to assist in meeting documentation requirements of the Center for Medical and Medicaid Services.

Name: \_\_\_\_\_

Current Training Program: \_\_\_\_\_ Start Date: \_\_\_\_\_

Medical School Graduation Date: \_\_\_\_\_ attach copy of diploma (translation if in foreign language)

ECFMG Issue Date: \_\_\_\_\_ attach copy of ECFMG Certificate

Chronological history of all activity from your Medical School Graduation to the present. Please do not leave any gaps. Please account for all time. Attach additional page if necessary.

<b>Dates</b>		<b>Place – Institution/Address/Country</b>	<b>Type of activity (Graduate training, studying, travel, research, professional practice, other employment)</b>
From	To		
From	To		
From	To		
From	To		
From	To		

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Patient Safety Awareness:  
Abbreviations and Legibility**

I agree not to use the following abbreviations (in the first column) in any manner, since they can be frequently misinterpreted and may cause harm to a patient.

<b>Abbreviation</b>	<b>Use Instead</b>
<b>MgS04</b>	Use complete spelling or <b>Mag Sulfate</b>
<b>MS04</b>	Use complete spelling or <b>Morphine</b>
<b>U or u</b>	Use “ <b>units</b> ”
<b>IU</b>	Use “ <b>units</b> ”
<b>X3d</b>	Use “ <b>for three days</b> ” or x 3 days
<b>Mg</b>	Use “ <b>microgram</b> ” or “ <b>mcg</b> ”
<b>Zero after decimal point (1.0)</b>	<b>Do not use terminal zeros</b> for doses expressed in <b>whole numbers</b>
<b>No zero before decimal point (.5)</b>	<b>Always use zero before a decimal point</b> when the does is <b>less than a whole unit.</b>
<b>QD or q.d.</b>	Use “ <b>daily</b> ”, “ <b>every day</b> ”, “ <b>q day</b> ”, or “ <b>Q24</b> ”
<b>QOD or q.o.d.</b>	Use “ <b>every other day</b> ” or “ <b>Q48 hrs</b> ”
<b>T.I.W.</b>	Use “ <b>three times weekly</b> ”

I agree to write legibly, including my signature, and further agree to include an indicative for any PRN order.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

- |   |                     |   |                           |
|---|---------------------|---|---------------------------|
| / | Attending physician | / | Resident physician        |
| / | Nurse Practitioner  | / | Student (Medical/Nursing) |
| / | Registered Nurse    | / | Physician Assistant       |
| / | Pharmacist          | / | Respiratory Therapist     |

## **Providence Hospital and Medical Centers Confidentiality Agreement**

It is the policy of Providence Hospital and Medical Centers to provide our patients with the level of privacy and confidentiality required under the law, whenever we are confided with medical information concerning any of our patients.

In the course of your work, you may have access ton confidential information (oral, written or computer supported information no otherwise available to the public at large) about patients, families and/or hospital business. Hospital business information includes computer programs, software and supporting documentation, technological improvement plans, strategic plans, financial information and employee information (including but not limited to co-workers and their families).

### **Therefore, I agree that:**

My right to enter or make use of confidential information is restricted to my need to know the data or information to perform my job responsibilities. I will keep my computer access password(s) confidential. If another method of accessing a computer system is used, such as an ID badge, I will restrict its use to myself. I will not discuss any confidential information in public areas, hallways, elevators, etc.

I will hold all confidential information of which I have knowledge in the truest confidence, as required by law. I agree to utilize confidential information obtained by me only for the benefit of the patient or in performance of my job responsibilities.

Unauthorized disclosure, copying and/or misuse of confidential information is a serous breach of duty and will result in disciplinary action up to and including termination of employment or contract with Providence Hospital and Medical Centers. Further, this agreement mandates compliance extending beyond employment, contract or association with PHMC, as required by law.

**I have read this Confidentiality Agreement and agree to its terms.**

Signature: \_\_\_\_\_

Name (print): \_\_\_\_\_

Date: \_\_\_\_\_