Application 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 at Providence Hospital. The term resident as used below means resident or fellow. Inquires regarding this application should be directed to the Manager Department of Medical Education, Providence Hospital and Medical Centers, 16001 West Nine Mile Road, Southfield, Michigan 48075, Phone: 248 849-3216, Fax 248 849-5324

Section I: To be Completed by the Visiting Resident Applicant

Applicant's Name ____

Social Security Number ___________________ Date of Birth ____________________

Medical School ____________________________________ Date Graduated_____________

Medical License Number and Expiration Date ______________________________________
Include copy of medical license

ECFMG # _________________________ Date ECFMG Passed _________________________
Include Copy of ECFMG Certificate

Current Residency/Fellowship Name ____

Current PGY Status _______________ Total all PGY Years of Training ___________________

Residency/Fellowship Director _______________________________ Phone _____________

Residency/Fellowship Institutional Sponsor ____

Please list all post-graduate training. Include all training program dates and residencies

1. ____

2. ____

3. ____

4. ____

Please also include a copy of your resume.
Current Home Address ______________________________Home Phone Number _______________

Pager Number ______________________________Email Address ____________________

Rotation at Providence Hospital ____

Beginning Date ____________ End Date _______________

If other than full-time at Providence Hospital, list hours and days available _______________

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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 recorded on the IRIS report for Medicare GME Payments.

Print Name of Department Head ____

Title ____Phone _________________

Signature of Department Head _____________________________________Date _______________

Section 3: To be completed by the Sponsoring Residency Program Director

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 faculty who are members of the Providence Hospital medical staff ___________

Print Name ____

Signature ____ Date ___________________

Medical Education Approval________________________________ Date _____________________