RESIDENT/FELLOW ROTATION APPLICATION

WESTERN RESERVE HOSPITAL
Proudly Physician Owned

Current training type: ☐ RESIDENT ☐ FELLOW

DEMOGRAPHIC INFORMATION

First Name:_____ Middle Name:_____ Last Name:_____

Credential(s):_____ Primary Phone:_____ Email:_____

Address: _____

DOB:_____ SS#: _____ NPI#:_____ DEA#: _____

Medicaid ORP#: _____

EMPLOYER INFORMATION

Employer:_____ Street Address:_____

City:_____ State:_____ Zip:_____

Contact Person:_____ Email Address:_____ Phone Number:_____

MEDICAL SCHOOL INFORMATION

Medical School:_____ Graduation Date:_____

RESIDENCY TRAINING INFORMATION

Initial Residency Program/Specialty:_____

Initial Residency Training Site:_____

Start Date:_____ End Date (or anticipated):_____

RESIDENTS

For the following questions, please consult your Medical Education staff to ensure accuracy:

Current Residency Program (if different from initial program):_____

Post Graduate Year:_____ Training Year in Current Program:_____

Please provide any off-cycle information (if applicable):

FELLOWS

For the following questions, please consult your Medical Education staff to ensure accuracy:

Residency Program you graduated from (if different from Initial Program):_____

Current Fellowship Program:_____

Post Graduate Year:_____ Training Year in Current Program:_____

Please provide any off-cycle information (if applicable):

ROTATION REQUEST(S)

Single Rotation Application: ☐ Academic Year Rotation Application: ☐

Rotation Name:_____Start date:_____End date:_____

Rotation Name:_____Start date:_____End date:_____

Comments:

STATE LICENSURE OR TRAINING CERTIFICATE

Do you have a valid State of Ohio training certificate or medical license? ☐ YES ☐ NO

ADDITIONAL INFORMATION

For the following questions, please consult your program coordinator to ensure accuracy:

Will you be attending didactic sessions at your home program? ☐ YES ☐ NO
What are the date(s) & time(s) of your didactic session(s)

Will you be participating in any clinical activities at your home program? ☐ YES ☐ NO
What dates/times are your clinical activities?

Will you be taking call at your home institution? ☐ YES ☐ NO
What dates are you taking call?

Are you taking any vacation time during your rotation? ☐ YES ☐ NO
Please add your dates of vacation below:

DISCLOSURE

Are you aware of limitations which would prevent you from performing the duties of the rotation?

☐ YES ☐ NO

Have you ever been convicted of a felony?

☐ YES ☐ NO

Submit to VisitingResidents@westernreservehospital.org

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DOCUMENT CHECKLIST

Once your application is approved, you will receive an email with instructions to login to our Residency Management Software, New Innovations and complete the In-Rotator checklist. This checklist allows you to submit all required documents electronically. Please have the following documents ready to upload in PDF format.

- ☐ **Medical School Diploma**
- ☐ **Current Curriculum Vitae**
- ☐ **Valid Ohio Training Certificate or Medical License**
- ☐ **Immunization Record**
  Immunization Record and/or Titers must include:
  - Tetanus, Diphtheria, Pertussis (TDAP)
  - Hepatitis B
  - Measles, Mumps, Rubella (MMR)
  - Polio
  - PPD or chest x-ray
  - Varicella or history of Chickenpox
  - Influenza (during flu season only, November - May)
- ☐ **Photograph**
  - Headshot photo for our records
  - Can be in Jpeg or comparable format
- ☐ **ECFMG Certificate (if applicable)**
- ☐ **Background Check Verification**
  - A letter from your medical education department verifying completion of a background check.
- ☐ **Letter of Good Standing**
- ☐ **Copy of Certificate of Liability Coverage**

Thank you for submitting your application with Western Reserve Hospital. Once a decision has been made regarding your application, you will be contacted via email.