



Visiting House Officer Application for Clinical Rotation

Section I: To be completed by the Applicant (print or type).

Last Name: _____ First Name: _____

Circle one each: M.D. or D.O. Male or Female Date of Birth: _____

Social Security Number: _____ Non-US Citizens: J-1 Visa H1B Visa

Home Address: _____

Email Address: _____

Phone#/Pager# _____ PGY: _____ Resident Fellow

Medical School: _____ Year Graduated: _____

Medical License Number: _____ State: _____ Exp. Date: _____

DEA Number: _____ NPI Number: _____

ECFMG Number: _____ Certification Date: _____

Home Institution Name: _____

Home Institution Address: _____

HFHS Rotation/Service Requested: _____

Length of Rotation (provide specific dates) From: _____ To: _____

Any time away from rotation (e.g., continuity clinics): _____

Hours/week: _____ If less than 40 hrs., how time will be used: _____

Epic EMR User, describe: _____

Attachments: Your application is not completed unless the following are attached (check those attached):

- Up-to-date CV, including all post-graduate training; list current program first
- Copy of Medical School Diploma
- Copy of Medical License (IF licensed in another state and rotation is less than 31 days, attach copy of out-of state license; if HFHS rotation is 31 or more days apply for MI License)
- Copy of ECFMG Certificate, if Foreign Medical Graduate
- Copy of DEA, if Full Michigan Medical License; not required for Educational License
- Copy of Michigan Controlled Substance License
- Infection Control Documentation (Proof of current TB immunization, Flu Vaccine required December through May)

House Officer Signature: _____ Date: _____

**Submit completed form, including required attachments,
to your Program Director for approval.**

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If you have questions, please contact HFH GME at 313-916-1601 or GME@hfhs.org

Last Name: _____ First Name: _____

Section II: To be completed by the Applicant's Program Director

- The house officer is not under any disciplinary restrictions at this time.
 - I approve the above rotation.
 - The house officer will continue to be paid by our institution during this HFHS rotation.
 - Professional liability coverage will be provided by HFHS during this rotation.
- Program Letter of Agreement (PLA) if required by the Sponsoring Institution (attach).**

Program Director (print): _____

Department/Service: _____

Email: _____

Phone number: _____ Fax number: _____

Program Director's Signature: _____ Date: _____

**Return completed form, including all required attachments,
to the Rotation-Specific HFH GME Program Coordinator**

Section III: To be completed by HFHS GME Program

- I approve the above rotation through my service.
 - Professional liability coverage will be provided by HFHS during this rotation.
- Visiting house officer is to observe only (e.g., no patient contact).**
- If PLA required by Sponsoring Institution; must be reviewed and signed by DME (attach).**
- Rotation requires Epic training (check all required)
- Inpatient Provider
- Ambulatory ASAP for ED Anesthesia Provider

Approving HFHS Program Director: _____

Supervising Physician Signature: _____ Date: _____

Submit completed form, including all required attachments, to the HFH GME Office

Section IV: To be completed by HFHS GME Office

Date Received: _____

- If PLA required; must be reviewed and signed by DME (attach).**
- People Soft Non-Employee ID: _____
- Entered into Database
- Request IT Access
- Schedule for Epic Training: Ambulatory IP Provider IP Surgeon Stork ASAP
- Request HFU On-line Orientation Curriculum; completion verified _____
- Provide resident on-boarding instructions (ID, password, HFU, 1st day parking)
- ID Issued (temporary returned), parking instructions provided
- ID Returned & Codes deactivated (date/initial): _____