

**MUNSON MEDICAL CENTER
OFFICE OF GRADUATE MEDICAL EDUCATION**

APPLICATION FOR CLINICAL ROTATION

1. DEMOGRAPHICS

NAME _____ SOCIAL SECURITY #: _____
HOME ADDRESS _____
CURRENT ADDRESS _____
HOME PHONE _____ CURRENT PHONE _____
EMAIL _____
MEDICAL EDUCATION _____
(College) (Grad Date)
CONTACT PERSON AT COLLEGE _____ PHONE# _____

2. ROTATION DESIRED

1. _____
(First Choice) (Dates)
2. _____
(Second Choice) (Dates)

If you have already arranged a rotation please list:

ROTATION ARRANGED _____
ATTENDING PHYSICIAN _____
DATES OF ROTATION: Beginning: _____ Ending: _____

3. TO BE COMPLETED ONLY BY RESIDENTS

Hospital _____ Residency _____

Program Director or Director of Medical Education _____

Address _____

Phone _____ email: _____

Year of Training: PGY 1 _____ PGY 2 _____ PGY 3 _____ PGY 4 _____

LICENSURE (Attach photocopies of ALL licenses)

Michigan Medical License #: _____ Exp. Date: _____

Michigan Pharmacy License #: _____ Exp. Date: _____

Drug Enforcement Agency (DEA#): _____ Exp. Date: _____

ECFMG LICENSE #: _____

4. DOCUMENTATION REQUIRED BEFORE BEGINNING THIS ROTATION

a. The following items must be sent directly from your school/program:

- Verification that you are a student or resident in good standing.
- Documentation of coverage by malpractice insurance for the requested rotation.

b. Submit documentation of:

- Immunity status against Hepatitis B
- Immunity against Varicella
- TB skin test

I hereby apply for the above stated rotation and agree to abide by the policies and procedures and Medical Staff bylaws of Munson Medical Center while on rotation at this institution.

Signature

Date

MMC GME use:

() **APPROVED**

() **NOT APPROVED**

Director of Medical Education

Date