

Application for Visiting Interns, Residents, and Fellows

Genesys Regional Medical Center

Medical Education Department

One Genesys Pkwy

Grand Blanc, MI 48439

(810) 606-5980 or (800) 233-2863

Fax: (810) 606-5990



www.genesys.org

We appreciate your interest in a rotation here at Genesys Regional Medical Center. Your completed application and the supporting documents must be submitted to the Medical Education Department at least 60 days prior to your requested rotation start date. The Medical Education Department will obtain approval of the preceptor/faculty member involved and get signature of the DME, providing all required documents are received.

1.) Complete Parts I & II:

- Applicant must complete Part I and sign on the “Applicant Signature” line.
- Current Program Director and DME must complete and sign Part II

2.) The following must be included with your application:

- A current Curriculum Vitae
- A copy of a valid Michigan Medical License, Michigan Controlled Substance License, and Federal DEA (if applicable)
- A copy of Medical School Diploma
- A letter verifying professional liability insurance coverage
- A letter of recommendation from your Internship or Residency Director, which identifies your current status in the program and evaluates your progress thus far.
- A copy of the letter from the accreditation agency (ACGME or AOA) verifying your current program’s status.
- A copy of your rotation schedule from your training program that specifically states the name of rotation at Genesys, the exact dates of the rotation, and the name of the hospital you are currently affiliated with.
- Proof of a recent Criminal Background Check
- A copy of current ACLS and BLS certification
- A copy of current TB immunization record
- A fully executed Affiliation Agreement
- A copy of ECFMG certificate (if applicable)

3.) Please forward your completed application to the address indicated above. If you have any questions regarding this rotation, please contact Mindy Valigura directly at (810) 606-5127 or mvaligura@genesys.org.

4.) Please call or send written notification 30 days in advance if a rotation needs to be cancelled.



PART I - APPLICANT

Applicant Name: _____	SS#: _____	D.O.B. _____
Home Address: _____	Phone: _____	
City: _____	State _____	Zip _____
Medical School: _____	Grad Mth/Yr: _____	Email: _____
Current Program: _____	Current PGY Level: _____	
Name of Home Institution: _____		
Home Institution Address: _____	City _____	State _____
	Zip _____	
Contact Person at Home Institution: _____	Phone: _____	Email: _____

Rotation Requested: _____	Supervising Attending: _____
Exact Dates of Rotation: ____/____/____	TO ____/____/____
Housing Needed: Yes _____	No _____

I hereby verify that the information and documents contained in this application are accurate, authentic and complete. I, as "Resident" agree to:

- 1.) Perform duties satisfactorily and to the best of my ability under the Medical Education Authority of the Hospital.
- 2.) Conform to all Hospital Policies, Procedures and Guidelines, including Medical Staff Rules and Regulations that are not inconsistent with this policy. (These can be reviewed in the Office of Medical Education).
- 3.) Arrange for housing and all other financial obligations through my home program and personal means. Genesys Regional Medical Center assumes no financial obligations for housing, stipend, insurance or other benefits.
- 4.) Fulfill all responsibilities and assignments defined by the Chief Instructor of the educational experience.
- 5.) Complete all medical records for which I am responsible in a timely manner and in full compliance with all policies and/or requirements established by the Hospital and/or Medical Staff and/or Attending Physician(s). I am aware that failure to complete all medical records responsibilities may result in a failed rotation.
- 6.) Unless authorized by the program director or specified in contractual relationships with the visiting trainees hospital, vacation and conference requests shall not be authorized during the rotation.
- 7.) Upon completion of the rotation, visiting trainee will be required to check out of GRMC by completing a clearance form in Medical Education. Failure to properly check out may result in an incomplete rotation.

Signature of Applicant: _____ **Date:** _____



PART II – THE HOME INSTITUTION MUST COMPLETE THIS SECTION BEFORE ROTATION CAN BE APPROVED

I Verify That....

- The above named Intern/Resident/Fellow is a trainee in good standing in a program that I direct.
- The above named Intern/Resident/Fellow has received all Hazardous Materials training and Universal Body Fluid exposure to blood borne pathogens training as required by State of Michigan and Federal Law.
- Genesys Regional Medical Center will assume no financial responsibilities (e.g. stipend, benefits, housing, etc) for this trainee.
- The above named Intern/Resident/Fellow will be adequately covered by Professional Liability Insurance for activities to be performed at Genesys Regional Medical Center under a policy issued to the home institution and program by:

Insurance Company: _____ Policy Number: _____

Limit per incident \$ _____ Limit per aggregate \$ _____ Policy Expiration: _____

I acknowledge that Genesys Regional Medical Center will claim the above named Intern/ Resident/ Fellow's time via I.R.I.S. Please estimate the percentage of time the above named Intern/Resident/Fellow will spend during the requested rotation.

Initial Residency Code: _____

Genesys Regional Medical Center _____% Non-Hospital Clinic Setting _____%

Other Hospital (s) _____% Hospital: _____%
Name Name

Signature of Home Institution Program Director _____ **Date:** _____

Signature of Home Institution DME: _____ **Date:** _____

PART III – TO BE COMPLETED BY GENESYS REGIONAL MEDICAL CENTER

Documents Received:

CV _____ Med License/DEA _____ Diploma _____ Malpract Info _____ Ltr of Rec _____
Rotation Schedule _____ Program Accred Letter _____ ACLS/BLS _____ TB _____
Criminal Background Check _____ ECFMG (if applicable) _____ Affiliation Agreement _____
Housing Scheduled and Fee Recvd _____

The above rotation has been approved:

Signature of DME: _____ **Date:** _____