

Applicant's Name \_\_\_\_\_

### **GRMERC Visiting Resident Application Instructions**

• For rotation requests occurring in the 2008 academic year, applications are due as follows:

July 1 through September 30  
All other months

April 15  
60 Days prior notice

- Resident must complete SECTION I of the application.
- Resident's Program Director must complete SECTION II of the application.
- Resident's Program Director or Personal Physician must complete the Health Information in SECTION II.
- All rotations will be scheduled for the calendar month.
- BOTH Sections I and II must be submitted together and the following documents must be attached to the application:

- A copy of Educational Limited License or permanent medical license & a copy of Controlled Substance License (if separate license)
- A copy of your ERAS Application (or equivalent)
- Proof of current ACLS certification
- Proof of current PALS or Neonatal Resuscitation Certifications (if requesting NICU rotation)
- Proof of current ATLS Certification (if requesting Trauma Rotation)
- Copy of ECFMG certificate if International Medical School Graduate
- Copy of medical school diploma
- Copy of Professional Liability Insurance Certificate which will provide coverage for Resident while rotating at GRMERC (GRMERC does not provide Liability Coverage for visiting Residents).
- A copy of Immunization History (form attached)
- Proof of Blood borne Pathogen & Universal Precaution training
- Proof of HIPAA Training
- Copy of rotational goals & objectives
- Completed background investigation release statement (form attached)

\$50 non-refundable application fee. (Does not apply to residents of GRMERC member institutions) Credit cards (AmEx, Visa, MC), money orders, cashier's checks, or business checks from the sponsoring institution will be accepted, **no personal checks or cash.** \*\*application fee subject to change\*\*

- Submit completed application via mail to:

Scheduling Manager  
1000 Monroe NW  
Grand Rapids, MI 49503

Applicant's Name \_\_\_\_\_

Or fax to 616-732-6259

- Submission of an application does not constitute approval of rotation request.
- You will be notified in writing of the approval status of your application.
- If you have questions, please email [schedulingmanager@grmerc.net](mailto:schedulingmanager@grmerc.net)

If accepted for a rotation at GRMERC, the Resident agrees to the following:

- 1) Resident will comply with all GRMERC and specific training site policies.
- 2) Resident will perform assigned duties to the best of his/her ability.
- 3) Resident will complete all medical records for which he/she is responsible in accordance with program and hospital guidelines.
- 4) Resident will provide his/her own housing.
- 5) Resident will complete any required orientations.
- 6) Resident will maintain patient confidentiality by following all HIPAA regulations.
- 7) Resident will log duty hours.

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*Applicant's Signature*

*Date*

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*Printed Name*

Applicant's Name \_\_\_\_\_

**Section I: To be completed by the Visiting Resident**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Email address \_\_\_\_\_

Contact Phone Number \_\_\_\_\_

Medical School \_\_\_\_\_ Graduation Date \_\_\_\_\_

Current Residency Program \_\_\_\_\_

Program address \_\_\_\_\_

Program Director \_\_\_\_\_ Phone \_\_\_\_\_

Residency Program Institutional Sponsor \_\_\_\_\_

**ROTATION REQUEST(s)**

**Dates**

1st Choice \_\_\_\_\_ TO \_\_\_\_\_

2nd Choice \_\_\_\_\_ TO \_\_\_\_\_

3rd Choice \_\_\_\_\_ TO \_\_\_\_\_

Applicant's Name \_\_\_\_\_

**BACKGROUND INVESTIGATION RELEASE STATEMENT**

Print Full Name \_\_\_\_\_

Other Names Used \_\_\_\_\_

Maiden Name \_\_\_\_\_

Date of Birth \* \_\_\_\_\_ Social Security Number \_\_\_\_\_

Drivers License Number \_\_\_\_\_ State \_\_\_\_\_

**Residence History: (please provide a seven (7) year history)**

Current address first – Include city, county, state, zip, country, and dates at each address:

| Address, City, County, State, Zip, Country | Dates at each address |
|--|-----------------------|
| 1.   |                       |
| 2.   |                       |
| 3.   |                       |
| 4.   |                       |
| 5.   |                       |
| 6.   |                       |
| 7.   |                       |

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**Employment History/Information (Please provide a seven (7) year history)**

**1. Name of employer** \_\_\_\_\_

Name of supervisor \_\_\_\_\_

Address, city, state, zip, country \_\_\_\_\_

Area code-Phone number \_\_\_\_\_ Dates of employment \_\_\_\_\_

**2. Name of employer** \_\_\_\_\_

Name of Supervisor \_\_\_\_\_

Address, city, state, zip, country \_\_\_\_\_

Area code-Phone number \_\_\_\_\_ Dates of employment \_\_\_\_\_

**3. Name of employer** \_\_\_\_\_

Name of Supervisor \_\_\_\_\_

Address, city, state, zip, country \_\_\_\_\_

Area code-Phone number \_\_\_\_\_ Dates of employment \_\_\_\_\_

**4. Name of employer** \_\_\_\_\_

Name of Supervisor \_\_\_\_\_

Address, city, state, zip, country \_\_\_\_\_

Area code-Phone number \_\_\_\_\_ Dates of employment \_\_\_\_\_

**5. Name of employer** \_\_\_\_\_

Name of Supervisor \_\_\_\_\_

Address, city, state, zip, country \_\_\_\_\_

Area code-Phone number \_\_\_\_\_ Dates of employment \_\_\_\_\_

Applicant's Name \_\_\_\_\_

\*Date of Birth to be used exclusively for record checking purposes and will not be used for any other purposes.

Prior to your Visiting Resident rotation and as a part of the Visiting Resident Application process with GRMERC, I understand that investigative background inquiries are going to be made on me. I understand that you will be requesting information from various Federal, State, Local and other agencies which maintain records concerning my past activities relating to my driving history, credit, criminal, civil and other experiences. These reports may also include inquiries regarding my educational history and past work experience and performance including reasons for termination of employment.

I authorize, without reservation, any party or agency contacted by this organization and its agents to furnish any of the above mentioned information or any other information requested. I understand that such information may contain my social security number. I release all parties from all liability for any damage that may result from furnishing that information to this organization.

I understand that the information generated, received or maintained during and as a result of this investigation will be maintained as confidential information.

A photocopy of this document is considered to be as valid as the original document.

I acknowledge that I have received a copy of my rights under the Fair Credit Reporting Act (attached to this application).

Signature \_\_\_\_\_ Date: \_\_\_\_\_

I verify that the information and documents contained in this application are accurate and complete.

\_\_\_\_\_  
*Applicant's Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Printed Name*



Applicant's Name \_\_\_\_\_

**Professional Liability Insurance**

Name of Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Limit Per Incident: \_\_\_\_\_

Limit Per Aggregate: \_\_\_\_\_

Policy Expiration Date: \_\_\_\_\_

Tail Coverage Included: \_\_\_\_\_

*(A copy of the Professional Liability Insurance must be attached to this application)*

I agree to all of the preceding terms and affirm that all submitted information is correct:

\_\_\_\_\_  
*Program Director's Signature* *Date*

\_\_\_\_\_  
*Printed Name*

Applicant's Name \_\_\_\_\_

## HEALTH ASSESSMENT SUMMARY SHEET

### IMMUNIZATION/VACCINE INFORMATION:

TB TEST #1 Date: \_\_\_\_\_ Results: \_\_\_\_\_ mm: \_\_\_\_\_

TB TEST #2 Date: \_\_\_\_\_ Results: \_\_\_\_\_ mm: \_\_\_\_\_

Annual TB Test Date: \_\_\_\_\_ Results: \_\_\_\_\_ mm: \_\_\_\_\_

**\*\*For Positive Testers Only\*\***

Last Positive Test Date: \_\_\_\_\_

Last Negative Chest X-Ray: \_\_\_\_\_

Evaluation/Treatment Record: \_\_\_\_\_

WHOPPING COUGH (DPT or DTaP ) \_\_\_\_\_

RUBELLA TITER \_\_\_\_\_

HEP B #1 \_\_\_\_\_

RUBEOLA TITER \_\_\_\_\_

HEP B #2 \_\_\_\_\_

VARICELLA TITER \_\_\_\_\_

HEP B #3 \_\_\_\_\_

TETANUS \_\_\_\_\_

HEP B TITER \_\_\_\_\_

The following are only required if above titers are **non-immune**:

MMR VACCINE DATES #1 \_\_\_\_\_ #2 \_\_\_\_\_

VARIVAX VACCINE DATES #1 \_\_\_\_\_ #2 \_\_\_\_\_

I have indicated the dates of the corresponding immunizations above and **have attached the documentation supporting these dates.**

Signature: \_\_\_\_\_

Date

Printed name of health care provider:

\_\_\_\_\_  
Name Title Date

I hereby release Spectrum Health Occupational Medicine, GRMERC & and Saint Mary's Health Care Employee Health Office and it's employees, staff and agents from all legal responsibility or liability that may arise from the disclosure of the information set forth above relating to my file.

\_\_\_\_\_  
*Applicant's Signature* Date

\_\_\_\_\_  
*Printed Name*