



## Application for Visiting Residents, Fellows and Interns

We appreciate your interest in a Visiting Resident rotation here at Sparrow Health System. Your application should be submitted to our Medical Education Department **sixty (60) days** prior to your requested rotation start date.

We are here to assist you. Please call us at 517.364.3676 if you have any questions regarding this application or the application process.

### **Please read the following information and follow the instructions:**

- 1) Complete Parts I & II:
  - Please read the requirements noted in Part I then sign on the "Signature of the Applicant" line to verify that you understand what is expected of you.
  - Your current Program Director should read and agree to Part II, then sign on the "Signature of the Program Director" line.
  
- 2) Include copies of the following licenses and certification **with** your application:
  - Michigan Educational Limited License **OR** Michigan Permanent Physician License and DEA License
  - Michigan Controlled Substance License (either Permanent or Educational Limited)
  - Proof of professional liability insurance coverage
  - Proof of current ACLS certification
  - A current résumé or curriculum vitae
  - A copy of the ECFMG certificate if applicable
  - A copy of the letter from accreditation agency (ACGME or AOA) verifying program's status
  - A copy of your medical school diploma **or** a dean's letter verifying that you graduated (or graduating) from your medical school.
  - A letter of good standing in current program
  - A signed copy of the Acknowledgement of Sparrow Health System Confidentiality and Security Obligations and/or Conditions agreement (can be found at end of this application)
  
- 3) Return your completed application to: Sparrow Health System, Office of Medical Education via email to [ridge.boedeker@sparrow.org](mailto:ridge.boedeker@sparrow.org) or it may faxed to: (517) 364-2763.
  
- 4) Send Sparrow Health System **written** notification 30 days prior to any cancellations.
  
- 5) The Visiting resident must obtain approval of the preceptor/faculty member involved in the requested rotation. You will receive an acceptance letter from the Office of Medical Education, which verifies your approval status.
  
- 6) You will receive a welcome email regarding security badge information, EMR training, computer access, parking and other important information regarding your rotation here approximately two weeks prior to your rotation.

*Please keep this instruction page for future reference*

# APPLICATION FOR VISITING RESIDENTS, FELLOWS and INTERNS

## PART I – APPLICANT

PLEASE PRINT OR TYPE YOUR RESPONSE

**Initial Program:** \_\_\_\_\_ (your first program after medical school)

**Service Requested:** \_\_\_\_\_ **Preceptor:** \_\_\_\_\_

**Dates:** FROM \_\_\_\_/\_\_\_\_/\_\_\_\_ TO \_\_\_\_/\_\_\_\_/\_\_\_\_ **PGY:** 1 2 3 4 5 **Fellow:** 1 2 3

Have you rotated on a service at Sparrow Hospital before:  Yes  No

Applicant Name: \_\_\_\_\_  MD  DO Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Home Phone #: \_\_\_\_\_ NPI #: \_\_\_\_\_ ECFMG # \_\_\_\_\_

Medical School: \_\_\_\_\_ Month, Day and Year of Graduation: \_\_\_\_/\_\_\_\_/\_\_\_\_

Citizenship:  US  Other (please specify): \_\_\_\_\_ VISA: \_\_\_\_\_

Program: \_\_\_\_\_ Institution: \_\_\_\_\_

Program Address: \_\_\_\_\_

Name of Program Director: \_\_\_\_\_ Telephone No.: \_\_\_\_\_

Fax No.: \_\_\_\_\_ Who Is Your Employer? \_\_\_\_\_

Primary E-Mail Address: \_\_\_\_\_@\_\_\_\_\_

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

- (a) Perform duties satisfactorily and to the best of my ability under the Medical Education authority of Sparrow Hospital.
- (b) Perform my duties and/or responsibilities as shall be determined by the Chief Instructor of the defined rotation in conformity with the conditions established by the Sparrow Hospital Department of Medical Education.
- (c) Perform my duties and discharge my responsibilities in compliance with state licensing laws, the standards of care and all Sparrow Hospital performance standards, policies, rules and regulations and procedure.
- (d) Obtain and maintain appropriate medical and controlled substance licenses to practice in the State of Michigan while performing my duties and responsibilities under this Agreement. Resident further understands that in the event the Resident does not obtain or maintain appropriate licensure for any reason, the Resident must inform the Hospital's Director of Medical Education immediately and will be suspended immediately without educational credit from all duties and responsibilities. The Resident may be subject to other disciplinary action for failing to obtain and maintain licensure.
- (e) 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).
- (f) Comply with program standards for total hours of duty in a workweek as a result of any other employment.
- (g) Arrange for housing and all other financial obligations through my home program and personal means. Sparrow Hospital assumes no financial obligations for housing, stipend, insurance or other benefits unless previously defined by an Institutional Affiliation Agreement.
- (h) Fulfill all responsibilities and assignments defined by the Chief Instructor of the educational experience.
- (I) Complete orientation for Surgery, Neonatology and other rotations when required by the service.
- (j) Be responsible as a licensed professional to insure that I understand all applicable duties and/or standards as required.
- (k) Not take vacation or other time-off during this rotation.

***I am aware that not fulfilling the above responsibilities may result in a failing evaluation and/or denial for a future rotation at Sparrow Hospital for other Residents and myself from my Residency program.***

Signature of the Applicant \_\_\_\_\_ Date \_\_\_\_\_

**PART II - PROGRAM DIRECTOR**

**I verify that:**

- (a) The above named Resident/Fellow/Intern is a trainee in good standing in a program, which I direct and that there has been no licensing, liability, disciplinary or other problems with this applicant.
  - (1) Program is accredited by  ACGME  AOA  Other (specify) \_\_\_\_\_
  - (2) Attach a copy of most recent accreditation letter.
- (b) The above named Resident/Fellow/Intern has received all Hazardous Materials training and Universal Body Fluid Precautions training, Blood Borne Pathogens training and has met immunization and other personal health status requirements of the State of Michigan and Federal Law/Regulations.
- (c) The above named Resident/Fellow/Intern's activities at Sparrow Hospital will be adequately covered by Professional Liability Insurance under a policy issued to the home institution and program by:

Name of Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Limit per incident \$ \_\_\_\_\_ Limit per aggregate \$ \_\_\_\_\_ Policy Expiration Date \_\_\_\_\_

- (d) Sparrow Hospital will assume no financial responsibilities for this trainee unless previously defined by an Institutional Affiliation Agreement.

*Please note any special training needs or problems Sparrow Hospital should be aware of in a letter to the Vice President of Medical Education, Ted Glynn, M.D., F.A.C.E.P. and attach it to this application*

**I agree that:** Sparrow Hospital will claim this Resident/Fellow/Intern's time via I.R.I.S.  Yes  No

Please estimate the **percentage** of time your Resident/Fellow/Intern will spend during the requested service at the following:

Sparrow Hospital \_\_\_\_\_% Non-Hospital Clinic Setting \_\_\_\_\_% Other Hospital(s):

Hospital \_\_\_\_\_% Hospital \_\_\_\_\_%  
(name) (name)

Signature of Program Director: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Sparrow Hospital agrees to:**

- (a) Provide the educational experience specified in this application according to the Visiting Resident policies of the Sparrow Hospital Education Committee.
- (b) Provide parking, meals and call quarters as deemed necessary by the Chief Instructor supervising the applicant.
- (c) Evaluate the applicant's performance accurately through the Chief Instructor of the service requested when the home residency program provides an evaluation form.
- (d) Provide the applicant with a copy of the House Staff Policy Manual.

**PART III - TO BE COMPLETED AT SPARROW HOSPITAL**

Service Approval Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Action by Sparrow Hospital Education Committee/Director of Medical Education:  Approved  Denied

Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Reason:

Signature of Vice President of Medical Education