



# Visiting House Officer Application for Clinical Rotation

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

HFHS Rotation/Service Requested: \_\_\_\_\_

Length of Rotation (provide exact dates) From: \_\_\_\_\_ To: \_\_\_\_\_

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

Email Address: \_\_\_\_\_

Cell Phone # \_\_\_\_\_ PGY: \_\_\_\_\_  Resident  Fellow

Medical School: \_\_\_\_\_ Year Graduated: \_\_\_\_\_

DEA Number: \_\_\_\_\_ NPI Number: \_\_\_\_\_

Home Institution Name, City, State: \_\_\_\_\_

Your current residency or fellowship program: \_\_\_\_\_

Name, email, & phone for your program coordinator: \_\_\_\_\_

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

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

Epic, describe your training/experience: \_\_\_\_\_  
**(EPIC training dates are either the day before rotation or the first day of rotation)**

**Your application is not complete unless all 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)
- ACLS (required for all rotations, PALS is an acceptable replacement for ACLS **for Peds rotations only**)
- BLS (required for all rotations, PALS acceptable replacement for BLS **for all rotations**)
- Rotation Schedule for Academic Year of Rotation Requested and Signed by Program Director

House Officer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

## Visiting House Officer Application for Clinical Rotation

If you have questions, please contact HFH GME at 313-916-1601 or [vlaport1@hfhs.org](mailto:vlaport1@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***