Visiting House Officer Application for Clinical Rotation

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

Select the Type of Rotation:

☐ Required Rotation ☐ Elective Rotation

HFHS Rotation/Service Requested:_____

Length of Rotation (provide exact dates) From:_____ **To:**_____

Last Name:_____ **First Name:**_____

☐ M.D. *or* ☐ D.O. ☐ Male *or* ☐ Female **Date of Birth:**_____

Social Security Number (Full SSN Required)**:**____-____-____ **Non-US Citizens:** ☐ J-1 Visa ☐ H1B Visa

Email Address:_____

Cell Phone #:_____ **Scrub Size:** ____ **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 <u>your</u> program coordinator:_____

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

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

☐ HFH EPIC Training Completed: _____

Onboarding Packets/Requirements will be sent through MedHub.

Your application is not complete until <u>all</u> the following requirements are uploaded to MedHub:

- ☐ 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, and COVID19 Vaccine Documentation)
- ☐ 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**)

House Officer Signature:_____ Date:_____

Submit completed form to your Program Director for approval.

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If you have questions, please contact HFH GME at 313-916-1601 or VHOGME@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) required by Henry Ford Hospital (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 *(if applicable):*_____ Date:_____

Submit completed form, including all required attachments, to the *HFH GME Office*