HENRY FORD HEALTH

Henry Ford Warren Hospital Graduate Medical Education In-Rotator Request Form

Instructions: Submit the **completed request** form no later than **60-Days** prior to the rotation start date to **kramos2@hfhs.org and mmarkie1@hfhs.org**

Rotation:	**Service: (Neuro, GI, etc)**
Staff Physician:	
Previous Rotator: ☐ Yes ☐ No **Case Coverage needed: July 1-June 30** ☐ Yes ☐ No **Type of rotation:** ☐ Audition ☐ Elective ☐ Core *REQUIRED - _____ percentage at HFWH and percentage at Base _____	
Requested Rotation Dates (start date/end date) (example May 1-31, 2026)	

Athena Access Needed: ☐ Yes ☐ No

Applicant Name			
Credentials	☐ DO ☐ MD ☐ DDS ☐ DPM ☐ Other: _____		
Gender:	☐ Male ☐ Female		
Date of Birth			
Full Social Security Number			
NPI		**License #:**	
ECFMG Number		**ECFMG Date**	
Phone Number			
Email:			
Medical School:			
Medical School Start Date			
Medical School End Date			
Applicant Home Institution (Hospital)			
Current Residency or Fellowship Program			
Current Program Year in Training (PGY)			
Program Start Date - month, day, and year			
Program End Date - month, day, and year			
Program Coordinator			
Coordinator Email			
Program Director			
PD Email			
Initial Program: ☐ Yes ☐ No (If you are in a fellowship mark **No**. Provide info below, if second fellowship attach additional page)			
If No, Initial Program Specialty	(i.e Internal Med)		
Initial Program Institution/Hospital			
Initial Program Start Date - month day, year			
Initial Program End Date - month, day, year			
Current Legacy Ascension Trainee/Associate	☐ Yes ☐ NO **If Yes Location:**		
Badge ID#	**Employee #**	**Computer Access ID:**	
Athena ID:	**Henry Ford assigned DEA#:**		

***Tentative approval pending completed application & checklist**