

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

### **GRMEP Visiting Resident Application Instructions**

- For rotation requests occurring in the 2012-2013 academic year (through June of 2013), requests must be made 90 days in advance.
- For rotation requests occurring in the 2012-2013 academic year, applications are due as follows:

July 1 through September 30  
All other months, 90 days prior notice

April 15

- Resident must complete the application.
- Resident must submit Health Information/proof of immunizations.
- Application must be submitted with the following documents:
  - A copy of Educational Limited License or Permanent medical license and a copy of the 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 Certification (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 GRMEP (Grand Rapids Medical Education Partners does not provide Liability Coverage for visiting residents).
  - A copy of Immunization History
    - Proof of current TB
  - Proof of Blood borne Pathogen & Universal Precaution training
  - Proof of HIPAA Training
  - Copy of rotational goals and objectives
  - Completed background investigation release statement (form attached)
  - \$150 non-refundable application fee. (Does not apply to Residents of Grand Rapids Medical Education Partners 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: Kimberly Longstreet, 1000 Monroe NW, Grand Rapids, MI 49503

Or fax to 616.233.6673

# GRAND RAPIDS MEDICAL EDUCATION PARTNERS

in affiliation with Michigan State University College of Human Medicine

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1000 Monroe Avenue NW | Grand Rapids, MI 49503 | 616.732.6200 | [grmep.org](http://grmep.org)

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

- 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 [kimberly.longstreet@grmep.org](mailto:kimberly.longstreet@grmep.org)

If accepted for a rotation at Grand Rapids Medical Education Partners, the Resident agrees to the following:

- 1) Resident will comply with all GRMEP 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*

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

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

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

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

(NOTE: Must be a school/university/institution address, **not** personal, i.e. yahoo, gmail, etc.)

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

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

Current Residency Program \_\_\_\_\_ Current PG Year \_\_\_\_\_

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

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

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

**ROTATION REQUEST(s)**

**Dates**

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

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

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

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**BACKGROUND INVESTIGATION RELEASE STATEMENT**

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

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

**Date of Birth \*** \_\_\_\_\_

**Social Security Number** \_\_\_\_\_

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

**Home Address History:**

**Current address first – Include city, county, state, zip, country, and dates at each address (Must have at least prior 10 years of home addresses):**

<b>Address, City, County, State, Zip, Country</b>	<b>Dates at each address</b>
1.	
2.	
3.	
4.	
5.	
6.	
7.	

**Employment History/Information**

**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 \_\_\_\_\_

Name: \_\_\_\_\_

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**6. Name of employer** \_\_\_\_\_

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

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

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

**7. Name of employer** \_\_\_\_\_

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

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

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

**8. Name of employer** \_\_\_\_\_

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

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

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

**9. Name of employer** \_\_\_\_\_

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

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

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

**10. Name of employer** \_\_\_\_\_

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

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

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

Name: \_\_\_\_\_

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

Prior to your Visiting Learner Rotation and as part of the Visiting Learner Application process with Grand Rapids Medical Education Partners, 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 employer or 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 company.

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.

Signature \_\_\_\_\_

Date \_\_\_\_\_

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

Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_

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Name \_\_\_\_\_

I authorize my home Program Director, to release to Grand Rapids Medical Education Partners, all performance and health information necessary to complete SECTION II of this application.

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

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

**SECTION II - TO BE COMPLETED BY RESIDENT'S PROGRAM DIRECTOR**

Please provide the following information regarding \_\_\_\_\_  
*Printed Resident's Name*

- YES     NO    The above-named Resident is currently in good standing.
- YES     NO    The above named Resident has the required academic background and necessary skills to participate in the requested rotation and is approved to take the requested rotation.

If there have been any academic/clinical performance, liability, disciplinary, or other problems with this Resident, please explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The above-named Resident completed Universal Precautions Training on \_\_\_\_\_ and HIPAA training on \_\_\_\_\_.  
*Date*  
*Date*

***(Copies of training must be attached to this application)***

\_\_\_\_\_ agrees to incur the cost of the above-named Resident's  
*Name of Resident's Institution*  
salary and benefits during his/her rotation(s) at Grand Rapids Medical Education Partners.

\_\_\_\_\_ agrees to provide professional liability coverage for the  
*Name of Resident's Institution*  
above-named Resident during his/her rotation at Grand Rapids Medical Education Partners. (Note: Grand Rapids Medical Education Partners does not provide liability coverage for visiting Residents)

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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*

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, Grand Rapids Medical Education Partners and Saint Mary's Health Care Employee Health Office and its 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*

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**Visiting Learner Application Fee**                      **\$150.00**  
**VL 5590-199**

**Learner Name:** \_\_\_\_\_

**Requested Rotation:** \_\_\_\_\_

**Dates of Rotation:** \_\_\_\_\_

**Credit Card Number:** \_\_\_\_\_

**Credit Card Expiration:** \_\_\_\_\_

**Learner Signature:** \_\_\_\_\_

**Mail to:**                      **Kimberly Longstreet**  
**GME Coordinator**  
**Grand Rapids Medical Education Partners**  
**1000 Monroe, NW**  
**Grand Rapids, MI 49503**

**Confidentially Fax to:**                      **616.233.6673**