

Application for Visiting Interns, Residents, and Fellows

Genesys Regional Medical Center

Medical Education Department

One Genesys Pkwy

Grand Blanc, MI 48439

(810) 606-5980 or (800) 233-2863

Fax: (810) 606-5990



www.genesys.org

We appreciate your interest in a rotation here at Genesys Regional Medical Center. Your completed application and the supporting documents must be submitted to the Medical Education Department at least 60 days prior to your requested rotation start date. The Medical Education Department will obtain approval of the preceptor/faculty member involved and get signature of the DME, providing all required documents are received.

1.) Complete Parts I & II:

- Applicant must complete Part I and sign on the “Applicant Signature” line.
- Current Program Director and DME must complete and sign Part II

2.) The following must be included with your application:

- A current Curriculum Vitae
- A copy of a valid Michigan Medical License, Michigan Controlled Substance License, and Federal DEA (if applicable)
- A copy of Medical School Diploma
- A letter verifying professional liability insurance coverage
- A letter of recommendation from your Internship or Residency Director, which identifies your current status in the program and evaluates your progress thus far.
- A copy of the letter from the accreditation agency (ACGME or AOA) verifying your current program’s status.
- A copy of your rotation schedule from your training program that specifically states the name of rotation at Genesys, the exact dates of the rotation, and the name of the hospital you are currently affiliated with.
- Proof of a recent Criminal Background Check
- A copy of current ACLS and BLS certification
- A copy of current TB immunization record
- A fully executed Affiliation Agreement
- A copy of ECFMG certificate (if applicable)

3.) Please forward your completed application to the address indicated above. If you have any questions regarding this rotation, please contact Mindy Valigura directly at (810) 606-5127 or mvaligura@genesys.org.

4.) Please call or send written notification 30 days in advance if a rotation needs to be cancelled.



PART I - APPLICANT

Applicant Name: _____	
SS#: _____	D.O.B. _____
Home Address: _____	Phone: _____
City: _____	State _____ Zip _____
	Email: _____
Medical School: _____	Grad
Mth/Yr: _____	

Rotation Requested: _____	Supervising Attending: _____
Exact Dates of Rotation: ____/____/____ TO ____/____/____	

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

- 1.) Perform duties satisfactorily and to the best of my ability under the Medical Education Authority of the Hospital.
- 2.) Conform to all Hospital Policies, Procedures and Guidelines, including Medical Staff Rules and Regulations that are not inconsistent with this policy. (These can be reviewed in the Office of Medical Education).
- 3.) Arrange for housing and all other financial obligations through my home program and personal means. Genesys Regional Medical Center assumes no financial obligations for housing, stipend, insurance or other benefits.
- 4.) Fulfill all responsibilities and assignments defined by the Chief Instructor of the educational



PART II – THE HOME INSTITUTION MUST COMPLETE THIS SECTION BEFORE ROTATION CAN BE APPROVED

I Verify That....

- The above named Intern/Resident/Fellow is a trainee in good standing in a program that I direct.
- The above named Intern/Resident/Fellow has received all Hazardous Materials training and Universal Body Fluid exposure to blood borne pathogens training as required by State of Michigan and Federal Law.
- Genesys Regional Medical Center will assume no financial responsibilities (e.g. stipend, benefits, housing, etc) for this trainee.
- The above named Intern/Resident/Fellow will be adequately covered by Professional Liability Insurance for activities to be performed at Genesys Regional Medical Center under a policy issued to the home institution and program by:

Insurance Company: _____ Policy Number:

Limit per incident \$ _____ Limit per aggregate \$ _____
Policy Expiration: _____

I acknowledge that Genesys Regional Medical Center will claim the above named Intern/ Resident/ Fellow's time via I.R.I.S. Please estimate the percentage of time the above named Intern/Resident/Fellow will spend during

PART III – TO BE COMPLETED BY GENESYS REGIONAL MEDICAL CENTER

Documents Received:

CV _____ Med License/DEA _____ Diploma _____ Malpract Info
_____ Ltr of Rec _____ Rotation Schedule _____ Program Accred
Letter _____ ACLS/BLS _____ TB _____ Criminal
Background Check _____ ECFMG (if applicable) _____ Affiliation
Agreement