

**Graduate Medical Education Department**

**Hospital of the University of Pennsylvania,**

**3400 Spruce Street Philadelphia, PA 19104**

**Telephone: 215-662-3957 / Fax: 215-615-4111**

### 2014 – 2015 APPLICATION FOR CLINICAL ROTATION

*This application* ***must be completed in its entirety*** *and all supporting materials*

*must be submitted with the application to the Office of Graduate Medical Education*

 ***no later than 60 days prior to the requested start*** *of the clinical educational experience.*

I hereby apply for appointment as a Rotating Graduate Medical Trainee at the Hospital of the University of Pennsylvania in Clinical Specialty \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Start date (MM/DD/YYYY) End Date (MM/DD/YYYY)

**Trainee Demographic Information:**

|  |  |
| --- | --- |
| First Name: |  |
| Last Name: |  |
| Degree(s): |  |
| Home Mailing Address: |  |
| City, State and Zip Code: |  |
| Home Phone: |  |
| Cell Phone: |  |
| Email: |  |
| Date of Birth: |  |
| Place of Birth – City, State, Country: |  |
| Citizenship: |  |
| USCIS Employment Verification ***(Visa/ Perm. Resident Card/EAD - if applicable - Attach copy)*** |  |
| Social Security Number:***(Mandatory)*** |  |
| NPI #: |  |

**Current Training Program Information:**

|  |  |
| --- | --- |
| Hospital (Employer): |  |
| Program Name: |  |
| Program Director Name: |  |
| Program Coordinator Name: |  |
| Program Coordinator’s Phone Number: |  |
| Program Coordinator’s Email Address: |  |

**Board Certification Information:**

|  |  |
| --- | --- |
| Program for which you are **CURRENTLY** working on for Board Certification |  |
| Program for which you **INITIALLY** sought Board Certification (If different from current program)  |  |

**Pennsylvania Licensing Information:**

|  |  |
| --- | --- |
| Do you currently hold a training license in Pennsylvania? (yes or no):  |  |
| If yes, note license number and attach copy: |  |

**Medical Education:**

|  |  |  |  |
| --- | --- | --- | --- |
| College / University (including Campus) | Degree | Start Date (MM/DD/YYYY) | End Date (MM/DD/YYYY) |
|  |  |  |  |
|  |  |  |  |

|  |  |
| --- | --- |
| Are you a graduate of a foreign medical school? (yes or no):  |  |
| If yes, attach copy of certificate and: * note current ECFMG Certification number:
* note ECFMG Certification issue date (MM/DD/YYYY):
 |  |
|  |

**Residency / Fellowship Training (list all programs in which you have trained):**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Hospital Name | City/State | Specialty | Start Date (MM/DD/YYYY) | End Date (MM/DD/YYYY) |
|  |  |  |  |  |
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**If any of the above training was NOT ACGME accredited, please note below:**

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|  |

**Certification by Trainee:**

*I certify that this Application, including all attachments and supplemental information, is true and correct to the best of my knowledge. I attest to the correctness and completeness of all information furnished. I fully understand that any significant misstatement or omission from this Application constitutes cause for denial of or dismissal from this educational opportunity.*

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

**Signature** **Date**

**Return To: UPHS Rotating Department Coordinator**

**Graduate Medical Education**

**University of Pennsylvania Health System**



Once form is completed please print, obtain appropriate signature(s), attach Rotator Check List and any required documents and submit to the Office of Graduate Medical Education.

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| --- | --- | --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Business Administrator/Program Director Signature | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Print Name | \_\_\_\_\_\_\_\_\_Date |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Program Coordinator | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Print Name | \_\_\_\_\_\_\_\_\_Date |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Office of Graduate Medical Education  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Print Name | \_\_\_\_\_\_\_\_\_Date |

FOR INTERNAL USE ONLY – OFFICE OF GRADUATE MEDICAL EDUCATION

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|  |  |  |  |  |   |
| **Date Received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Date Entered: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Effective 7/01/2013**