Oakwood
Healthcare System

Application for Non-Oakwood Residents, Fellows and Interns

We appreciate your interest in rotating here at Oakwood Healthcare System (OHS). Your completed application must be approved in advance by the Director of Medical Education. Your application should be submitted to Medical Education **ninety (90) days** in advance of your requested rotation start date. If your application is not received **ninety (90) days** in advance, your rotation may be denied. **Please read the following requirements and instructions carefully.**

1) **PART I:**
Please read the requirements noted in Part I then sign on the "Signature of the Applicant" line to verify that you understand what is expected of you.

PART II:
Your current Program Director should read and agree to Part II then sign on the "Signature of the Program Director" line. Also, your current Director of Medical Education **MUST** sign in the designated area **PRIOR** to submitting this form.

PART III:
It is the responsibility of the resident requesting the rotation to obtain the signature of the precepting physician PRIOR to submitting the rotation application. Please have the precepting physician fill in **ALL** information requested in Part III & sign in the space marked "Service Approval". **Any incomplete application will not be processed.** This could delay the start date or result in denial of the rotation.

PART IV:
The Medical Education Office will obtain the approval signature of the Oakwood Healthcare System Director of Medical Education.

2) **LICENSES AND CERTIFICATIONS:**
Please include copies of the following licenses and certification **WITH** your application:

- Copy of actual Michigan Educational Limited License OR Michigan Permanent Physicians License and DEA license (website verification document not acceptable)
- Copy of actual Michigan Controlled Substance License (website verification document not acceptable)
- Proof of current ACLS certification
- Copy of ECFMG Certificate (if applicable)
- Proof of current TB skin test
- Proof of Flu vaccine during Flu season
- Proof of Liability Coverage
- Medical School Diploma

3) **MANDATORY ROTATION REQUIREMENT:**
All residents/fellows requesting rotations at any Oakwood facility MUST complete mandatory EPIC computer training PRIOR to the start of the rotation**.** Training for most residents will be 10 hours broken into two 5 hour sessions. Sessions will be scheduled two weeks apart. Contact the Medical Education Office at 313-436-2577 for availability. **Failure to complete this training will result in the cancellation of the rotation. NO EXCEPTIONS!**

4) **DEPOSITS:**
All required deposits should be paid **PRIOR** to the start of the rotation. Deposit checks will be returned at the end of the rotation when items are returned. Deposit checks will be cashed for any items not returned at the end of the rotation. **You will NOT be allowed to start your rotation until all deposits are received. NO EXCEPTIONS!**

Required Deposit Items:

Photo ID Badge ($50.00): All residents will be required to obtain a photo ID badge to be worn at **ALL** times while on our premises. The Security Office will not distribute a badge without authorization from the Medical Education Department.

Oakwood lab coat ($20.00): A visiting resident lab coat is required unless you have a generic lab coat with no embroidered institutional information. You will not be allowed to start without meeting one of these criteria.

Optional Items:

Pager ($45.00): You may opt to use your home institution's pager but you must list the complete 10 digit number in PART I under "beeper". Note: You must use an Oakwood pager if you are doing a CCU rotation.

Scrubs: You have the option of using your own scrubs or those provided in our scrub machines. T he scrub machines have a 2 pair limit.

Please forward your completed application and check to:

Oakwood Healthcare System
Medical Education
Visiting Resident Application
18101 Oakwood Blvd.
Dearborn, MI 48124

5) Meal tokens will be given at check-in for overnight calls only.

6) Send OHS written notification thirty (30) days in advance, when a rotation needs to be canceled.

VERY IMPORTANT INFORMATION – PLEASE READ CAREFULLY

Report to the Medical Education Office prior to beginning your rotation to sign in and obtain the necessary required items and orientation packet. Office hours are Monday thru Friday, 7:30am to 5:00pm. At the conclusion of your rotation you will need to return all deposit items including your photo ID badge to the Medical Education Office. If any portion of the rotation will occur at more than one Oakwood Hospital site (i.e. Oakwood Dearborn, Annapolis, Southshore or Heritage), you **MUST** check in to that site's Medical Education or Medical Staff Office on the first day you are rotating at that facility to verify they have copies of your credentialing documents. **If you do not check in or have the proper identification, you may be asked to leave immediately. You will NOT be permitted to complete your rotation at that facility until proper documents and identification is obtained.**

The Oakwood photo ID badge MUST be visible at all times while on Oakwood premises.

Application for Visiting Residents, Fellows and Interns

PART I-APPLICANT

Rotation Requested: _____ Preceptor: _____

Dates: **FROM** ___/___/___ **TO** ___/___/___

PGY: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 **FELLOW:** ☐ 6 ☐ 7 ☐ 8

Have you rotated on a service at OHS before: ☐ **Yes** ☐ **No** **If yes, what service(s):**

_____ _____ _____

_____ _____ _____

Attach photo here

Applicant Name: _____

Home Address: _____

City/State/Zip: _____

Full Social Security #: ____ -____-_____ DOB: _____

NPI #: _____

Home Phone #: (___)___ - _____ Cell Phone#: ___ ___ - ____ Beeper #: _____

Name of Emergency Contact: _____ Relationship: _____

Phone #: ___ ___ - ____ Alternate Phone #: ___ ___ - ____

Medical School: _____ Year/Month of Graduation: ____/____

Previous Training Program: (Include all training programs to date)

1)

2)

3)

Citizenship: ☐ **U.S.** ☐ **Other** (please specify) _____ Visa: _____

Program: _____ Institution: _____

Program Address: _____

Program Director: _____ Telephone #: (___)____-_____

Fax #: (___)____-_____ **ECFMG #:** (if applicable) _____ Date ECFMG Certified: ___/___/___

Application for Visiting Residents, Fellows and Interns

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

(a) Perform my duties and/or responsibilities as shall be determined by the Preceptor of the defined rotation in conformity with the conditions established by the **OHS**, **Medical Education**.

(b) Complete all medical records, for which I am responsible, in a timely manner and in full compliance with all policies and/or requirements established by the Hospital and/or Medical Staff and/or Attending Physician(s).

(c) Arrange for housing and all other financial obligations through my home program and personal means. OHS assumes no financial obligations for housing, stipend, conferences, insurance or other benefits unless previously defined by an Institutional Affiliation Agreement.

I am aware that not fulfilling the above responsibilities may result in a failing evaluation and/or denial for a future rotation at OHS.

Signature of Applicant: _____ Date: ___/___/____

PART II - PROGRAM DIRECTOR & DIRECTOR OF MEDICAL EDUCATION-SENDING HOSPITAL

I verify that:

(a) The above name Resident/Fellow/Intern is a trainee in good standing in a program, which I direct, and that there have been no licensing, liability, disciplinary or other problems with this applicant.

(b) The above name Resident/Fellow/Intern has received all hazardous material training and universal body fluid precautions training and exposure to blood borne pathogens training as required by the State of Michigan and Federal Law.

(c) OHS will assume no financial responsibilities for this applicant unless previously defined by an Institutional Affiliation Agreement.

(d) The above name Resident/Fellow/Intern's activities at OHS will be adequately covered by Professional Liability Insurance under a policy issued to the home institution and program by:

Name of Insurance Company: _____ Policy Number: _____

Limit per Incident $_____ Limit per aggregate $_____

Policy Expiration Date: ___/___/____

Please note any special training needs or problems OHS should be aware of in a letter to the Director of Medical Education and attach it to this application.

I agree OHS will claim this applicant's time via I.R.I.S. ☐ Yes ☐ No

Please estimate the percentage of time this applicant will spend during the requested service at the following:

Oakwood Hospital ____ % Non-Hospital Clinic Setting ____ % Other Hospital(s): Please indicate

Hospital _____ _____ % Hospital _____ _____ %
(name) (name)

Signature of Program Director: _____ Date: ___/___/____
(Sending Hospital)

Signature of Director of Medical Education: _____ Date: ___/___/___
(Sending Hospital)

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PART III – TO BE FILLED OUT BY PRECEPTING PHYSICIAN

Program Service Approval Signature: _____ Date: ___/____/____
(Signature of Preceptor)

Will any portion of this rotation occur at another Oakwood Hospital site? Please check additional locations and list percentage of time spent at each location during the rotation.

____ Oakwood Hospital & Medical Center _____ %

____ Oakwood Annapolis Hospital _____ %

____ Oakwood Southshore Hospital _____ %

____ Oakwood Heritage Hospital _____ %

NOTE: THIS SECTION MUST BE FILLED OUT OR THE RESIDENT WILL NOT BE ALLOWED TO ROTATE AT OTHER OAKWOOD HOSPITAL SITES

OHS agrees to:

(a) Provide the educational experience specified in this application according to the visiting resident policies of the OHS Medical Education Committee.

(b) Provide parking, on-call meals, beeper and call quarters as deemed necessary by the Preceptor supervising the applicant.

(c) Evaluate the applicant's performance accurately through the Preceptor of the service requested when an evaluation form is provided by the home residency program.

PART IV - TO BE COMPLETED BY OHS DIRECTOR OF MEDICAL EDUCATION ONLY

Action by OHS, Director of Medical Education: ☐ Approved ☐ Denied

Date: ___/___/____ Reason: _____

Signature of Director of Medical Education: _____