# **VISITING RESIDENT/FELLOW APPLICATION AND ONBOARDING FORM**

Please complete the below form in its **entirety** for your visiting resident/fellow rotation at Cleveland Clinic Florida-Weston. **Incomplete forms will not be accepted** as all information is required for proper onboarding and compliance with the CCFL-Weston Visiting Resident/Fellow Program. \*Please check your preferred email address listed below for all communications.

## **DEMOGRAPHICS INFORMATION**

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| Full Name: Click here to enter text.\*Preferred Email Address: Click here to enter text.Work Email Address (if different from above): Click here to enter text.Phone Number: Click here to enter text.Date of Birth: Click here to enter a date.Gender: Choose an item.Citizenship Status: Choose an item.Social Security Number: Click here to enter text.*Permanent Mailing Address*Street: Click here to enter text. City: Click here to enter text. State: Click here to enter text.Country: Click here to enter text. Postal Code: Click here to enter text. |

## **GENERAL INFORMATION**

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| PGY Level: Choose an item.NPI Number: Click here to enter text.Credentials: Choose an item.CCFL Rotation: Click here to enter text.Start Date: Click here to enter a date. End Date: Click here to enter a date. Have you ever completed a medical student rotation at CCFL before? Choose an item. Have you even been a visiting trainee at CCFL or are currently scheduled for a rotation? Choose an item. |

## **EDUCATION INFORMATION**

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| Medical School Name: Click here to enter text.Degree: Click here to enter text.Start Date: Click here to enter a date. End Date: Click here to enter a date.Graduate School Name: Click here to enter text.Degree: Click here to enter text.Start Date: Click here to enter a date. End Date: Click here to enter a date.*International Medical Graduates Only*: Are you certified by the Educational Commission for Foreign Medical Graduates (ECFMG)? Choose an item.Number: Click here to enter text. Date Issued: Click here to enter a date. |

## **CURRENT POST GRADUATE TRAINING PROGRAM**

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| Hospital: Click here to enter text.Type: Choose an item.Specialty: Click here to enter text.Start Date: Click here to enter a date. End Date: Click here to enter a date. |

## **POST GRADUATE TRAINING HISTORY (PAST INTERNSHIP, RESIDENCY, FELLOWSHIP)**

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| Hospital: Click here to enter text.Type: Choose an item.Specialty: Click here to enter text.Start Date: Click here to enter a date. End Date: Click here to enter a date. |

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| Hospital: Click here to enter text.Type: Choose an item.Specialty: Click here to enter text.Start Date: Click here to enter a date. End Date: Click here to enter a date. |

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| Hospital: Click here to enter text.Type: Choose an item.Specialty: Click here to enter text.Start Date: Click here to enter a date. End Date: Click here to enter a date. |

## **LICENSURE – FLORIDA MEDICAL LICENSE**

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| Do you have a Florida Medical License: Choose an item.Florida Medical License Number: Click here to enter text. Exp. Date: Click here to enter a date.Do you have a Florida DEA License? Choose an item. License Number: Click here to enter text.  |

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| Are you aware of any limitations that would prevent you from performing the duties of the training position for what you are applying? Choose an item. | If yes, please explain: Click here to enter text. |

## Typing your name below acknowledges the above information is complete, accurate and true.

Name: Click here to enter text.

Date: Click here to enter a date.

*Completed forms should be submitted to:* *VisitingResidentsFL@ccf.org*