Mail to
Graduate Medical/Medical Student Education Department
CLEVELAND CLINIC FLORIDA
2950 Cleveland Clinic Boulevard
Weston, Florida 33331
Phone: 954/659-5229
Fax: 954/659-5622
Toll Free Number: 1-866-293-7866 ext. 56211

APPLICATION FOR VISITING RESIDENT

Please Print or Type

APPLICATION FOR: _____Dates: _____ _____
Service/Department From To

PGY LEVEL_____ NPI # _____

Have you been a visiting observer at Cleveland Clinic Florida before? ❒ Yes ❒ No

_____
Last Name First Name Middle Name Social Security Number

_____
Present Mailing Address (Street, City, State, Country, Postal Code)

_____
Permanent Mailing Address (Street, City, State, Country, Postal Code) Date of Birth Place of Birth

_____
Area Code/Home Phone Number Area Code/Work Phone Number Area Code/Fax Number E-mail address

EDUCATION - Name and Location of School - Dates of Attendance and Degree Obtained

Medical Degree (School, Location, Date of Graduation- month –day- year) **PLEASE SUBMIT A COPY OF YOUR MEDICAL SCHOOL DIPLOMA**
_____

Residency (Specialty & Graduate Level, Hospital, Location, Date of Completion, month date and year s)
_____

_____

_____

LIST OTHER ADVANCED APPOINTMENTS INCLUDING CURRENT ONE (HOSPITAL, LOCATION, DATE):

_____

_____

_____

_____

Please attach a copy of your curriculum vitae.

HEALTH REQUIREMENTS:
Visitors are required to provide proof of immunizations, specifically:

1. Varicella, Rubella, Titers, and/or proof of immunizations, specifically:
2. Recent documents TST test or recent chest x-ray (<1year) if known TST positive
3. Proof of hepatitis B immunity (serology)
4. Proof of bloodborne pathogen training or training will be provided prior to starting rotation

DO YOU HAVE A FLORIDA MEDICAL LICENSE NUMBER? IF YES, PLEASE SUBMIT A COPY OF YOUR MEDICAL LICENSE. ❒ No

❒ Yes Number:_____ Permanent:_____ Training Certificate:_____

Are you aware of any limitation that would prevent you from performing the duties of the training position for which you are applying?

❒ No

❒ Yes

Explain:_____

DO YOU HAVE A NARCOTIC REGISTRY LICENSE IN FLORIDA (DEA)? IF YES, PLEASE SUBMIT A COPY OF YOUR DEA CERTIFICATE. ❒ No

❒ Yes DEA Number:_____

Are you a citizen of the United States? ❒ Yes ❒ No Type of Visa:_____ (please submit a copy of visa)

INTERNATIONAL MEDICAL GRADUATES ONLY:
Are you certified by the Educational Commission for Foreign Medical Graduates (ECFMG)?

❒ No ❒ Yes Certificate number _____ Certification valid through date: _____

Examination Taken

VQE 1 _____ 2_____ NBME 1_____ 2_____

FMGEMS 1 _____ 2_____ USMLE 1 _____ 2_____

PLEASE SUBMIT A COPY OF YOUR CURRENT VALID ECFMG CERTIFICATE.

I certify that the information given on this form is true, accurate and complete.

_____ Date _____

Signature of Applicant

FOR CLEVELAND CLINIC FLORIDA USE ONLY:

Approved by:

_____

Department Program Director or Supervising Physician

_____

Chairman, Graduate Medical Education Committee