# **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**

|  |
| --- |
| 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**

|  |
| --- |
| 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**

|  |
| --- |
| 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**

|  |
| --- |
| 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)**

|  |
| --- |
| 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. |

|  |
| --- |
| 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. |

|  |
| --- |
| 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**

|  |
| --- |
| 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. |

|  |  |
| --- | --- |
| 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*](mailto:VisitingResidentsFL@ccf.org)