Cleveland Clinic
Akron General

Cleveland Clinic Akron General
Application for Visiting Resident/Fellow Physician

Only applications with ALL required documents will be considered. Materials must be received no later than one month prior to the rotation.

Applications are good for one academic year.

☐ **Completed Affiliate Application Form** ☐ **Proof of Liability Insurance Coverage during rotation** ☐ **Current Curriculum Vitae** ☐ **Valid ECFMG Certificate** *International Medical School graduates only* ☐ **Photograph** *Headshot for badge; should be in jpeg or compatible format* ☐ **Valid Ohio Medical License or Training Certificate** *If you do not have one, please visit http://www.med.ohio.gov/Applicants/TrainingCertificates(MD,DO,DPM).aspx to apply. We must have your acknowledgement letter for you to begin.*	☐ **Copy of Medical School Diploma** **Must be in English* ☐ **NPI Number** **Must be included on the Application* ☐ **Immunization Records** If rotation is approved, you will be required to provide proof of immunizations prior to rotation *Immunization Record and/or Titers must include:* • *Tetanus, Diphtheria, Pertussis (TDAP)* • *Hepatitis B* • *Measles, Mumps, Rubella (MMR)* • *Polio* • *PPD or chest x-ray* • *Varicella or history of Chickenpox* • *Influenza (during flu season only, November 1-May)* ☐ **Background Check Verification** *A letter from your Medical Education department verifying completion of a background check*

Submit the application with ALL the above documents to:

Renee Messenger
MessenR@ccf.org
330-344-6666

Visiting Resident/Fellow Application

Demographic Information

Current Training Type: Resident ☐ Fellow ☐

Full Name: _____ Credentials: _____

Primary Phone: _____ Email: _____

Social Security #: _____ Male ☐ Female ☐

NPI Number: _____ Birthdate: _____

Home Address: _____ City, State, Zip: _____

Cleveland Clinic Akron General Rotation Information

Rotation Request Type: Single Rotation Application ☐ Academic Year Application ☐

Rotation Requested:_____ Dates Requested: _____-_____

Returning to Akron General for other rotations?

Department: _____ Date: _____

Medical School Information

Name of Medical School: _____ Date of Graduation: _____

A copy of your Medical School Diploma must be provided along with your application.

If applicable, ECFMG Certification Issuance: _____Number:_____

A copy of your ECFMG Certificate must be provided along with your application.

Employer Information

Employer: _____ Address: _____

Contact Person: _____ Phone: _____ Email: _____

Please list all U.S. Residency or Fellowship training in Chronological order in addition to attaching a copy of current C.V.

Current Residency/Fellowship Training						
Specialty	Hospital	City	State	Graduate Level	Begin Date	End Date
Previous Residency/Fellowship Training						
Specialty	Hospital	City	State	Graduate Level	Begin Date	End Date
Specialty	Hospital	City	State	Graduate Level	Begin Date	End Date
Specialty	Hospital	City	State	Graduate Level	Begin Date	End Date

State Licensure or Training Certificate

Do you have a valid Permanent Ohio Medical License? Yes ☐ No ☐

If yes, License Number: _____

If no, do you currently hold an Ohio State Medical Board Training Certificate? Yes ☐ No ☐
If no, we must receive your acknowledgement letter from the state before you can begin.

If yes, Training Certificate Number: _____
A copy of your Training Certificate must be provided along with your application.

Additional Information

Will you be attending didactic sessions at your home program? Yes ☐ No ☐
If yes, what are the dates & times of your didactic sessions?

Will you participating in any clinical activities at your home program? Yes ☐ No ☐
If yes, what are the dates/times of your clinical activities?

Will you be taking call at your home institution? Yes ☐ No ☐
If yes, what dates are you taking call?

Are you taking any vacations during your rotation? Yes ☐ No ☐
If yes, please list your vacation dates:

I CERTIFY THAT THE INFORMATION GIVEN ON THIS APPLICATION IS TRUE, ACCURATE, AND COMPLETE

_____ _____
APPLICANTS SIGNATURE DATE

AUTHORIZATION FOR EXTRAMURAL ELECTIVE AND VERIFCATION THAT SPONSORING INSTITUION WILL PROVIDE MALPRACTICE INSURANCE BY TRAINING PROGRAM DIRECTOR OR AUTHORIZED INDIVUDAL OF THE SPONSORING INSITUTION

_____ _____
SPONSORING INSTITUTION APPROVAL DATE

Emergency Contact Information:

Name & Relationship of Contact: _____ Phone: _____

Disclosure

Akron General will ensure a non-discriminatory environment regarding personnel/employment practices. These practices are administered without regard to race, color, religion, sex, sexual orientation, gender identity, genetic information, national origin, ancestry, handicap, age, pregnancy, marital status, disability, military status, veteran or Vietnam Era Veteran. Akron General Medical Center complies with all federal regulations, and is committed to a program of equal opportunity which is consistent with the goals, mission and values of our institution.