

INGHAM

REGIONAL MEDICAL CENTER

A McLAREN HEALTH SERVICE

Application for Visiting Interns, Residents, and Fellows

We appreciate your interest in Ingham Regional Medical Center. Our Director of Medical Education must approve this application in advance. The approval process should go smoothly if you follow these instructions:

1. Print or type your responses.
2. Complete this four-part application with ALL PAGES in order (Parts I-IV).
3. Applicant should sign on the "Applicant's Signature" line (Part I: Application)
4. Current Program Director should sign Part II
5. Your application will only be considered when all requested information is received.
(use the checklist below)

- Photocopy of your original Internship or Residency Application from current Hospital.
- Copy of Current CV
- A certificate of Professional Liability insurance coverage for activities to be performed at Ingham Regional Medical Center.
- Letter of Good Standing.
- Photocopy of a valid and current Michigan Medical or Osteopathic License, Michigan controlled Substance License and Federal DEA License (if applicable), valid through the time period you are requesting.
- Photocopy of a current ACGME/AOA Program Approval Letter.
- Photocopy of ECFMG Certificate (if applicable)

The Visiting Resident **must** confirm their rotation at least one month prior to the start of the rotation by calling or emailing Gary Riley. (517) 975-7886 or gary.riley@irmc.org.

After you have completed the Application, **please attached all supporting documents** and send in at least 2 months in advance to:

Gary P. Riley
Ingham Regional Medical Center
Medical Education
401 W. Greenlawn Ave.
Lansing MI, 48910

Or Fax to: (517) 975-7880

If you have any questions, please call Ingham Regional Medical Center, Medical Education (517) 975-7886 or email gary.riley@irmc.org



Medical Education

Phone: 517.334.2195
800.424.3544

Fax: 517.372.6757

Earl J. Reisdorff, M.D., F.A.C.E.P.
Director

Sheri Clarke, M.P.A.
Administrative Director

R. Taylor Scott, D.O.
Osteopathic Director

Laura Mohr, Ph.D.
Behavioral Science

Karen Jury
Residency Coordinator II
Internship
Emergency Medicine

Brenda Pearson
Residency Coordinator I
Family Practice
General Surgery
Obstetrics/Gynecology
Orthopedic Surgery

Gary Riley
Technical Development Coordinator
Anesthesiology
Internal Medicine
Medical Students
Nephrology Fellowship
Visiting Residents

Department Mission Statement

To foster a spirit of inquiry throughout the hospital, cultivate teaching, and develop competent physicians serving the Mid-Michigan community

PART I. APPLICANT: (ALL FIELDS MUST BE ANSWERED)

Applicant Name: _____ SS# _____ - _____ - _____

Street Address: _____

City: _____ State: _____ Zip: _____ Phone: () _____ - _____

Email: _____

APPLICANT'S CURRENT INTERNSHIP/RESIDENCY/FELLOWSHIP STATUS:

Program (*Circle One*) 1 2 3 4 5 Institution: _____

Street Address: _____

City: _____ State: _____ Zip: _____ Phone: () _____ - _____

Program Director: _____ Phone: () _____ - _____

Residency Coordinator Email: _____ Phone: () _____ - _____

Current Specialty: _____ Initial Specialty: _____

Medical School: _____ Graduation Date: _____

INGHAM REGIONAL MEDICAL CENTER SERVICE REQUESTED:

Service Requested: _____

Preceptor Requested: _____

Dates Requested: ____/____/____ to ____/____/____ (MUST BE EXACT DATES OF ROTATION)

I hereby verify that the information and documents contained in this application are accurate, authentic, and complete.

I AGREE TO:

1. Perform duties satisfactorily and to the best of my ability under the Medical Education Authority of the hospital.
2. Conform to all Hospital Policies, Procedures and Guidelines including Medical Staff Rules and regulation that are not inconsistent with this policy. (These can be reviewed in the Office of Medical Education).
3. Arrange for housing and all other financial obligations and personal means through my home program. Ingham Regional Medical Center assumes no financial obligations for housing, stipend, insurance, or other benefits.
4. Fulfill all responsibilities and assignments defined by the Chief Instructor of the education experience.
5. COMPLETE ALL MEDICAL RECORDS required by the Attending Physicians.

Applicant's Signature: _____ Date: ____/____/____

PART II. PROGRAM DIRECTOR:

I VERIFY THAT:

- The above named Intern/Resident/Fellow is a trainee in good standing in a program, which I direct.
- The above named Intern/Resident/Fellow has received a Hazardous Materials training and Universal Body Fluid exposure to blood borne pathogen training as required by State of Michigan and Federal Law.
- Ingham Regional Medical Center will assume no financial responsibilities (i.e. stipend, benefits, housing, etc.) for this trainee.
- The above named Intern/Resident/Fellow will be adequately covered by Professional Liability Insurance for activities to be performed a Ingham Regional Medical Center. The above named Intern/Resident/Fellow has submitted Certificate of Professional Liability Insurance coverage to Ingham Regional Medical Center.

POLICY INFORMATION:

Insurance company: _____ Policy Number _____

POLICY LIMITS:

Per Incident \$ _____ Per Aggregate \$ _____

INTERN RESIDENT INFORMATION SERVICE INFORMATION:

I agree that Ingham Regional Medical Center will Claim this Intern's/Resident's/ Fellow's time via IRIS:

Yes No

Estimate **Percentage** of time Visiting Intern/Resident/Fellow will spend during the requested service at the following:

Ingham Regional Medical Center _____%

Other Hospital _____%

Hospital Name _____%

Hospital Name _____%

Non-Hospital Clinic Setting _____%

Signature of Program Director _____ Date: ____/____/____

PART III. TO BE COMPLETED AT INGHAM REGIONAL MEDICAL CENTER

APPROVAL BY DIRECTOR OF INGHAM REGIONAL MEDICAL CENTER:

Approval Signature _____ Date: ____/____/____

Telephone Number: (517) 334-2195

INGHAM REGIONAL MEDICAL CENTER AGREES TO:

1. Provide the Education experience specified in this application according to the Visiting Resident policies of Ingham Regional Medical Center, which the applicant may review in the Office of Medical Education.
2. Provide parking and call quarters as deemed necessary by the Chief Instructor supervising the applicant.
3. Evaluate the applicant's performance fairly through the Chief Instructor of the service requested.

ACTION BY INGHAM REGIONAL MEDICAL CENTER EDUCATION COMMITTEE:

Approved By: _____ Date: ____/____/____

Denied: _____ Date: ____/____/____

Deficiencies to be corrected:

The Ingham Regional Medical Center Education Committee will meet next on: _____

If you have any questions, please contact Medical Education at (517) 334-2195 or 800-424-3544. You can also contact us on our website. www.irmcmehed.org