Visiting Resident/Subspecialty Resident Application

UNC Hospitals Office of Graduate Medical Education
● 101 Manning Drive ● Chapel Hill, NC 27514 ● Phone: (984)974-1072 ● Fax: (984)974-0290 ●

~Send your completed application to the Program Coordinator of your desired UNC Hospitals rotation~

Visit https://www.uncmedicalcenter.org/uncmc/professional-education-and-services/office-of-graduate-medical-education/visiting-residents/ **for additional requirements**

Section 1 - To be completed *ELECTRONICALLY* by the Resident/Subspecialty Resident. Print the completed form and have YOUR Program Director sign and date. Forward signed application to UNC Hospitals.

Legal Name		Sponsoring (home) Institution	
Birth Date		Institution Address	
Social Security #			
Current Phone #		Institution Telephone	
Current Address		Current Program	
		Program Coordinator	
Email Address		Coordinator Phone/Email	
Medical/Dental/Graduate School		Current PGY Status	
Inclusive Dates (mm/dd/yyyy)-(mm/dd/yyyy)		Rotation (at UNC Hospitals)	
Degree		Start Date	
NPI # (required)		End Date	

Do you have a NCMB or NCDB license: ☐ Yes ☐ No

License #: _____ Expiration Date: _____

Have you ever rotated at UNC Hospitals: ☐ Yes ☐ No

If yes, inclusive dates: (mm/yyyy-mm/yyyy) _____

Do you have an ECFMG Certificate: ☐ Yes ☐ No

Certificate Number: _____ Date Issued: _____

Training History: Be sure to include ALL training programs, each year listed separately, with start/end dates in mm/dd/yyyy format, including your current/in-progress year. If there are any gaps, please include a brief explanation with dates, activities, and location(s).

Section 2 - To be completed by the Residency Program at the sponsoring (home) institution

I approve the above rotation and verify that this resident will continue to be paid during their rotation and malpractice insurance will be provided by _____ and will cover his/her activities.

Signature of Program Director _____ *Date* _____

Section 3 - To be completed by the UNC Hospitals Residency Program in which the resident will rotate

Issue Physician Code Numbers ☐ YES ☐ NO

THE ABOVE ROTATION HAS BEEN APPROVED

Signature of UNC Hospitals Program Director _____ *Date* _____

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RELEASE OF INFORMATION

I hereby grant permission to the University of North Carolina Health Care System and UNC Hospitals' Office of Graduate Medical Education (collectively, "UNC Health") to release information about me that it collects or maintains. I understand that this information will be released only for purposes deemed necessary for the effective administration of UNC Health, such as maintenance of accreditation, compliance with requirements for financial support of graduate medical education, and data management and preservation. I understand that my Social Security number will be released only in the limited situations authorized by law. I understand further that this information will be released only to entities that have agreed, via contract with UNC Health, to keep it confidential.

Date: _____

_____
Signature

_____
Printed Name