Visiting Resident Application

UNC Hospitals Office of Graduate Medical Education

Visit the GME website for all visiting resident requirements:
https://www.uncmedicalcenter.org/uncmc/professional-education-and-services/office-of-graduate-medical-education/visiting-residents/

Plan to begin a minimum of 12 weeks prior to your proposed start date to complete the necessary paperwork and get everything approved by the institution, especially if you are coming from out of state and will need time to obtain a license from the North Carolina Medical Board.

Application must be completed electronically and signed by both the sponsoring institution and UNC program directors before it is submitted to the UNC GME Office for processing.

Visiting Resident Information

Legal Name: _____ **Birth Date:** ___/___/___
First Middle Last

Address: _____ **Phone:** ____-____-____
Street Address Apt/Suite

_____ **SSN:** ____-____-____
City State Zip Code

Email Address: _____ **NPI:** _____

Medical/Dental School: _____ **Inclusive Dates:** ____/___/____ to ____/___/____

Degree Obtained: _____

Do you have a NCMB or NCDB License? ☐ **Yes** ☐ **No**
If yes, License Number: _____
Expiration Date: ___/___/___

Do you have an ECFMG Certificate? ☐ **Yes** ☐ **No**
If yes, Certificate Number: _____
Date Issued: ___/___/___

Sponsoring (home) Institution Information

Institution Name: _____

Institution Address: _____
Street Address Apt/Suite

_____
City State Zip Code

Current Program: _____ **Current PGY Level:** ____

Program Coordinator: _____ **PC Phone:** ____-____-____ **PC Email:**_____

Training History (List all training and/or relevant employment (e.g. Chief resident, hospitalist, etc.) beginning immediately after medical school, including your current/in-progress year.)

1. Program: _____
   Institution/School: _____
   Inclusive Dates: ___/___/___ to ___/___/___
2. Program: _____
   Institution/School: _____
   Inclusive Dates: ___/___/___ to ___/___/___
3. Program: _____
   Institution/School: _____
   Inclusive Dates: ___/___/___ to ___/___/___
4. Program: _____
   Institution/School: _____
   Inclusive Dates: ___/___/___ to ___/___/___
5. Program: _____
   Institution/School: _____
   Inclusive Dates: ___/___/___ to ___/___/___
6. Program: _____
   Institution/School: _____
   Inclusive Dates: ___/___/___ to ___/___/___

There cannot be any gaps in your post-graduate timeline. For any time between programs/appointments, please include the specific date range and reason/location here. For example, "DD/MM/YYYY – DD/MM/YYYY = Vacation between med school and residency."

_____
_____
_____

Rotation Information

Rotation (program at UNC): _____ **Have you rotated at UNC before?** ☐ **Yes** ☐ **No**

Upcoming Rotation Start Date: ___/___/___ **Upcoming Rotation End Date:** ___/___/___

Sponsoring (home) Institution Approval & Insurance Provider

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

Signature of Program Director _____ Date _____

UNC Hospital Program Approval

I approve the above rotation.

Signature of UNC Hospitals Program Director _____ Date _____

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

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

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