

**Memorial Health University Medical Center
Department of Graduate Medical Education
Savannah, Georgia**

ROTATING RESIDENT APPLICATION FORM

All applications must be accompanied by proof of malpractice coverage by your parent hospital as well as a letter from your residency program director or designated official stating that you are a resident in good standing, all immunizations are in order, and you have been approved for this outside rotation. Please note that your application will not be considered for approval without these documents.
PLEASE PRINT ALL RESPONSES BELOW.

Rotation Requested: _____
Dates Requested: From: ____/____/____ To: ____/____/____

Name: _____ SS#: _____

Present Address: _____
(Street) (City) (State) (Zip Code)

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____

E-Mail Address: _____

Employed By: _____

Current Residency Training Program: _____ PGY- _____

Anticipated Date of Graduation from Residency Program: ____/____/____

Name of Medical School: _____ Graduation Date: ____/____/____

Georgia License # _____ Expiration Date: ____/____/____

ECFMG Certificate # _____ Expiration #: ____/____/____
(If Applicable)

X _____
Applicant Signature Date

For Office Use Only	
Completed Application Received By: ____/____/____	
X _____	_____
GME Coordinator's Approval	Date
Hosp. Pager#: _____ Prescription#: _____	Doctor#: _____ DEA#: _____