Dear Applicant,

This application is for residents and fellows interested in clinical rotations at Carilion. We welcome your interest and have included in this packet all the information you need in order to apply as well as a summary of our process below.

Critical Information

1. We do not accept faxed or scanned applications, applications residents mail directly to us, or those missing information or documentation, or applications arriving fewer than 8 weeks prior to anticipated arrival.

2. Applicants seeking employment opportunities with a Carilion residency program at CRMH, must
   a.) meet the program's residency applicant criteria described in Education & Research at CarilionClinic.org under Applying on the residency/fellowship page of interest,
   b.) contact the residency program to determine whether or not the program will sponsor the visit, and
   c.) include this information in the application.

3. Applicants not seeking resident employment opportunities at CRMH must
   a.) find a sponsor among those available in Doctors & Providers at CarilionClinic.org,
   b). contact that person to insure s/he will sponsor the visit, and
   c.) include the sponsoring preceptor's contact information on the application.

4. To speed your application through your clinical office, complete the top part of the Carilion Immunization Record and have a health care provider summarize your immunization records onto the bottom half so you can submit the completed form with your application.

5. Housing is not available.

Process

1. It is the applicant's responsibility to include all paperwork the home program does not provide and to obtain the required signatures through Section 2.

2. Upon receiving the application, we will review it for completion. Only completed applications are forwarded to the programs for review and signature.

3. We will email you the results. We will include an invitation to come and information you need to consider before accepting the rotation as well as on-line training to be completed within the two weeks prior to arrival.

4. If we can accommodate you, you will then have 5 days to accept or decline the rotation.

5. If you accept the rotation, we will email a confirmation. Do not make plans to come without a confirmation email from Carilion's Visiting Student Affairs.

You may print the application and complete it by hand or you may complete it on-line and then print to complete checklists and forward for signature. Please print this cover letter at the same time and retain it for future reference. All applicants, including those who have been to Carilion before, must include the first 3 pages in the attached Orientation Packet with their application.

In all e-mail correspondence and applications, use your program e-mail address, if you have one.

Warm regards,

Carilion Visiting Student Affairs
Carilion Roanoke Memorial Hospital
P.O. Box 13367
Roanoke, VA 24033-33067
Physical Location: 1906 Belleview Avenue, SE, 1South
Office: (540) 981-7829
Fax: (540) 983-1189

CARILION CLINIC

Visiting Resident Application

Residents who desire to observe or participate in patient care for educational purposes (a "Rotation") in a Carilion Clinic owned or affiliated site ("Carilion Clinic Site") must complete the application below. " Resident" as used below means intern, resident, or fellow. All visiting Residents must be approved by the Carilion Clinic Designated Institutional Official (DIO) and/or Director of Osteopathic Medical Education (DOME) or the designated administrator at the Carilion Clinic Site. It is the responsibility of the visiting Resident or his/her medical education department to complete this application in its entirety including the provision of required documents and signatures. Failure to complete the requirements will result in non-approval of the requested Rotation.

The completed application must be submitted **at least 8 weeks prior** to the start of the requested rotation with the following:

- ☐ **Proof of malpractice insurance, if applicable**
- ☐ **Copy of your current State of VA medical license (Out-of-State residents must obtain a temporary VA training license prior to applying.**
- ☐ **Copy of ECFMG certificate, if applicable**
- ☐ **Copy of your Medical School Diploma (translated, if in a foreign language)**
- ☐ **Completed HR Forms** (included in this packet)

Section 1: ***To be completed by the Visiting Resident Applicant*** **PLEASE COMPLETE ON-LINE OR PRINT LEGIBLY.**

Name_____ ☐**M or** ☐**F** _____ _____
First Middle Last Last 4 digits of SSN MMDD of DOB

Address _____ _____
Street City, State, Zip Code Mobile Number

Email _____ **Home Phone** _____ **Emergency Contact** _____

Credentials ☐ MD ☐ DO ☐ DDS ☐ DPM ☐ Other: _____ **Relationship** _____ **Phone** _____

Virginia License No. _____ **Expiration** _____ **NPI No.** _____
(Out-of-State Residents must obtain a temporary VA license prior to the applying.) MM/DD/YY

Medical School (full name) _____ **Graduation** _____
MM/DD/YY

Current Residency Program _____ **Current Postgraduate Year** _____

☐ Allopathic (ACGME) ☐ Osteopathic (AOA) ☐ Podiatric ☐ Dental **Total of all PGY Years of Training** _____

Home or Sponsoring Institution _____

Address _____ _____
Street City, State, Zip Code

Residency Director _____ **Phone** _____ **Email**_____

Program Coordinator _____ **Phone** _____ **Email**_____

Rotation Requested _____ **or**_____ **at** _____
Name and Location of Carilion Clinic Rotation Site

_____ _____ _____
Name of Carilion Program Director or Supervising Physician Site Contact Person Contact's Phone

	Start Date (Mondays Only)	End Date (Weekdays Only)	List Any Hours or Days per Week You Will NOT Be at Rotation Site (if applicable)
1st Choice			
2nd Choice			

Y	N	
☐	☐	I am immune to rubella, rubeola, and varicella.
☐	☐	I am free of active pulmonary tuberculosis.
☐	☐	I have had a PPD skin test within the previous year. Date of last PPD (MM/DD/YY) _____
☐	☐	Results were negative. (If you answered No, you must attach proof of a negative chest x-ray obtained within the last year.)
☐	☐	I am immune to hepatitis B.

Please read the following and attest to the fact that you agree with them by signing your name below.
I am responsible for complying with all applicable laws, statutes and regulations and the policies, procedures, and rules of Carilion Clinic and safeguarding confidential information, including but not limited to patient information disclosed orally, in writing, or by any other media or manner, obtained during my participation in my Rotation.

I am responsible for making appropriate arrangements for transportation to and from Carilion Clinic and, if necessary, appropriate housing arrangements. I also understand that applications missing documentation or information will not be processed and that I should not make plans to come to Carilion before receiving confirmation from Carilion's Visiting Student Services Office.

I am responsible for providing my own health insurance. In the event of an emergency, Carilion Clinic shall provide emergency care as is provided to its employees, but I shall be responsible for any charge thus generated.

I am responsible for providing Carilion Clinic with any evaluation form and the address for submission of any evaluation form that my Sponsoring Institution wants Carilion Clinic to complete regarding my Rotation.

I understand that Carilion Clinic has the sole right to exclude or terminate me from participation in a Rotation in the event that I am not performing to the satisfaction of Carilion Clinic, including, but not limited to material breaches of any of Carilion Clinic's rules and policies, or am interfering with the operations of Carilion Clinic.

I understand that Carilion Clinic has the sole right to determine and designate, and from time to time to change, those patients, patient groups, and clinical areas which may be included in my Rotation.

I am not debarred, excluded or otherwise precluded from participating in any federally funded health care program, including but not limited to Medicare and Medicaid.

Finally, I understand that I am not an employee of Carilion Clinic, and Carilion Clinic has no responsibility for providing compensation or benefits to me during my Rotation. During my Rotation, I will not hold myself out as the employee or agent of Carilion Clinic.

I have attached **Goals and Objectives** for the above-requested rotation.

Signature	Date	Print Your Name

Section 2: ***To be completed by the Sponsoring Institution's Department of Medical Education*** **PLEASE PRINT LEGIBLY.**

The Sponsoring Institution agrees to the following.

Term: The term of this agreement between the parties shall be for the duration of the requested Rotation. Carilion Clinic does, however, maintain sole authority for determining the Resident's ability to participate in the Rotation.

Professional Liability: At its own expense, the Sponsoring Institution will provide professional liability coverage for each Resident in amounts of not less than the following limits: (i) the per claim limit shall be equal to or greater than the damage cap for medical malpractice claims against physicians in the Commonwealth of Virginia, as increased from time to time by Va. Code § 8.01-581.15; (ii) the annual aggregate limit shall be equal to or greater than three (3) times the damage cap for medical malpractice claims against physicians in the Commonwealth of Virginia, as increased from time to time by Va. Code § 8.01-581.15. If Sponsoring Institution maintains a claims-made policy, Sponsoring Institution shall also provide, at its own expense, "tail" insurance coverage upon termination of its policy extending to all periods during which the Resident was in a Rotation at a Carilion Clinic Site under this agreement. The obligations of Sponsoring Institution to maintain tail coverage under this paragraph shall survive termination or expiration of this agreement. Sponsoring Institution shall provide Carilion Clinic Site with certificates from the insurance company or companies evidencing this coverage. Nothing herein shall prohibit Sponsoring Institution from self-insuring such liability coverage.

Billing: To the extent permitted by applicable law and regulations, Carilion Clinic Site will include on its Medicare and Medicaid cost reports the time that the Resident is in a Rotation at Carilion Clinic Site. Carilion Clinic Site and its attending physicians shall have sole responsibility for billing third-party payers, including Medicare and Medicaid, for all patient care services provided by Carilion Clinic Site and its attending physicians, including, to the extent permitted by applicable laws and regulations, the care rendered by attending physicians in which the Resident participates or for the services of attending physicians of Carilion Clinic Site.

Financial Support and Benefits: The Sponsoring Institution shall be solely responsible for providing salary, health, and welfare benefits to the Resident during the Rotation, and the Resident shall not be considered an employee of Carilion Clinic Site. The parties shall at all times, be independent contractors and not employees or agents of another, and shall not hold themselves out as employees or agents of each other.

I approve the visiting Resident Rotation described above and verify that this Resident is in good standing in the program.

Name of Authorizing Individual at Sponsoring Institution	Signature	Date (MM/DD/YY)
Title	Printed Name of Sponsoring Institution	

FAXED OR SCANNED SIGNATURES ARE NOT ACCEPTED.
Mail Completed Application with all Required Documentation Attached
to Carilion Clinic Visiting Student Affairs, CRMH, PO Box 13367, Roanoke, VA 24033-3367
Phone (540) 981-8274

Section 3: ***To be completed by the Carilion Program Director or Supervising Physician of Carilion Clinic Site***

I approve the above Resident Rotation at Carilion Clinic including the attached Goals and Objectives and will ensure that adequate resident supervision will occur.

Printed Name _____ ☐ Program Director ☐ Supervising Physician

Printed Name of Carilion Clinic Site	Signature	Date (MM/DD/YY)

Return Completed Original to Visiting Student Affairs, CRMH, PO Box 13367, Roanoke, VA 24033-3367.

Section 4: ***To be completed by Carilion Clinic Authorizing Individual: Carilion Clinic DIO/DOME and/or Designated Administrator of Carilion Clinic Site*** **PLEASE PRINT LEGIBLY.**

I approve the above Resident Rotation to Carilion Clinic.

Printed Name	Title	Signature	Date (MM/DD/YY)

Return Completed Original to Visiting Student Affairs, CRMH, PO Box 13367, Roanoke, VA 24033-3367.

NOTES: