

Mail to
Graduate Medical/Medical Student Education Department
CLEVELAND CLINIC FLORIDA
2950 Cleveland Clinic Boulevard
Weston, Florida 33331
Phone: 954/659-5229
Fax: 954/659-5622
Toll Free Number: 1-866-293-7866 ext. 56211

APPLICATION FOR VISITING RESIDENT

Please Print or Type

APPLICATION FOR: _____ Dates: _____

PGY LEVEL _____ Service/Department _____ From _____ To _____
NPI # _____

Have you been a visiting observer at Cleveland Clinic Florida before? ☐ Yes ☐ No

Last Name First Name Middle Name Social Security Number

Present Mailing Address (Street, City, State, Country, Postal Code)

Permanent Mailing Address (Street, City, State, Country, Postal Code) Date of Birth Place of Birth

Area Code/Home Phone Number Area Code/Work Phone Number Area Code/Fax Number E-mail address

EDUCATION - Name and Location of School - Dates of Attendance and Degree Obtained

Medical Degree (School, Location, Date of Graduation- month -day- year) **PLEASE SUBMIT A COPY OF YOUR MEDICAL SCHOOL DIPLOMA**

Residency (Specialty & Graduate Level, Hospital, Location, Date of Completion, month date and year s)

LIST OTHER ADVANCED APPOINTMENTS INCLUDING CURRENT ONE (HOSPITAL, LOCATION, DATE):

Please attach a copy of your curriculum vitae.

HEALTH REQUIREMENTS:

Visitors are required to provide proof of immunizations, specifically:

1. Varicella, Rubella, Titers, and/or proof of immunizations, specifically:
2. Recent documents TST test or recent chest x-ray (<1year) if known TST positive
3. Proof of hepatitis B immunity (serology)
4. Proof of bloodborne pathogen training or training will be provided prior to starting rotation

DO YOU HAVE A FLORIDA MEDICAL LICENSE NUMBER? IF YES, PLEASE SUBMIT A COPY OF YOUR MEDICAL LICENSE. ☐ No

☐ Yes Number: _____ Permanent: _____ Training Certificate: _____

Are you aware of any limitation that would prevent you from performing the duties of the training position for which you are applying?

☐ No

☐ Yes

Explain: _____

DO YOU HAVE A NARCOTIC REGISTRY LICENSE IN FLORIDA (DEA)? IF YES, PLEASE SUBMIT A COPY OF YOUR DEA CERTIFICATE. ☐ No

☐ Yes DEA Number: _____

Are you a citizen of the United States? ☐ Yes ☐ No Type of Visa: _____ (please submit a copy of visa)

INTERNATIONAL MEDICAL GRADUATES ONLY:

Are you certified by the Educational Commission for Foreign Medical Graduates (ECFMG)?

☐ No

☐ Yes Certificate number _____ Certification valid through date: _____
Examination Taken

VQE 1 _____ 2 _____

NBME 1 _____ 2 _____

FMGEMS 1 _____ 2 _____

USMLE 1 _____ 2 _____

PLEASE SUBMIT A COPY OF YOUR CURRENT VALID ECFMG CERTIFICATE.

I certify that the information given on this form is true, accurate and complete.

Signature of Applicant Date _____

FOR CLEVELAND CLINIC FLORIDA USE ONLY:

Approved by:

Department Program Director or Supervising Physician

Chairman, Graduate Medical Education Committee