



MAHEC Graduate Medical Education
VISITING RESIDENT APPLICATION FORM

Please allow 60-90 days for processing

This form must be typed

Rotation desired (program name): _____

Rotation dates: From: _____ To: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Medical School Attended: (Name and Location): _____

_____ Degree Awarded: _____ Degree Date: _____

If applicable, are you ECFMG certified? Yes No

INFORMATION REGARDING YOUR CURRENT RESIDENCY PROGRAM:

PGY Level: _____

Program Director (Name): _____

Home Institution (Full name & address): _____

Please include a letter from your program director and/or Director of Medical Education stating that you are in good standing and indicating approval of elective and elective dates.

Home Institution GME Contact: _____

Phone: _____ Fax: _____ Email: _____

Applicant Signature: _____ Date: _____

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HOST DEPARTMENT APPROVAL. This visiting resident is accepted to participate in the requested elective.

Host "MAHEC" P.D. Signature: _____ **Date:** _____

Host "MAHEC" GME Signature: _____ **Date:** _____