THE UNIVERSITY OF ARIZONA | COLLEGE OF MEDICINE

UNIVERSITY OF ARIZONA COLLEGE OF MEDICINE

VISITING RESIDENT APPLICATION FORM

Please allow 90-120 days for processing
This form must be typed

Program Name: _____

Rotation Name: _____

Requested Rotation Dates: From: _____ To: _____

From: _____ To: _____

Last Name:_____First Name:_____Credentials: _____

Address: _____

City: _____ State:_____Zip: _____

Date of Birth: _____ Phone: _____Email:_____

Medical School Attended: _____Graduation Date: _____

Gender: Male ☐ Female ☐ Non-Binary ☐

If applicable, are you ECFMG certified? Yes ☐ No ☐

National Provider Identification (NPI): _____

INFORMATION REGARDING YOUR CURRENT TRAINING PROGRAM:

PGY Level: PGY -- Resident ☐ Fellow ☐

Program Director (Name): _____

Training Program: _____

Home Institution (Full name & address): _____

_____

Program Coordinator Contact: _____

Phone:_____Fax:_____Email: _____

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TO BE COMPLETED BY HOST INSTITUTION PROGRAM

HOST DEPARTMENT APPROVAL. Visiting resident is accepted to participate in an elective rotation

(Name of rotation - as listed in New Innovations): _____

Host Site Director Signature: _____Date: _____