Graduate Medical Education

Rotation Intake Form

Legacy GME requires 30-days to process all requests

Visiting Trainee Information:

Last Name: *legal name*

First Name: *legal name*

Middle Initial:

DOB:

SS#: *(xxx-xx-xxxx - last 4 digits only for students)*

Gender:

Cell: *(xxx-xxx-xxxx)*

Pager: *If applicable*

Email:

Home Institution:

Institution Address:

Institution Coordinator:

Coordinator Email:

Coordinator Phone: *(xxx-xxx-xxxx)*

Trainee Type: Choose one

Current Program Year:

Program End Date:

Rotation Information:

Legacy Rotation:

Legacy Preceptor:

Legacy Rotation Site: ☐ **Emanuel/ RCH** ☐ **Good Samaritan** ☐ **Meridian Park** ☐ **Mt Hood** ☐ **Salmon Creek** ☐ **Silverton** ☐ **Unity** ☐ **LMG Clinic**

Rotation Start:

Rotation End:

Prior Epic Experience: YES ◯ NO ◯

Residents & Fellows:

Degree: Choose one

Speciality:

PG Year:

Medical and/or Dental School:

Graduation Date:

NPI#:

Medical License #:

Expiration Date:

DEA # - only if you hold your own: *Not the DEA # assigned by your home institition*

ECFMG #:

Expiration Date:

For Internal Medicine Student Rotations ONLY - one rotation, per student, per academic year.

Audition Rotation: YES ◯ NO ◯

Trainee required remediation and/or failed a clinical course rotation: YES ◯ NO ◯

Trainee is in good standing and is qualified to do a clinical rotation: YES ◯ NO ◯

Future Plans?

PLEASE RETURN YOUR COMPLETED FORM TO: **Contact:**

LEMC/LGSMC Internal Medicine ICU/Wards:	JB Kerzan	jkerzan@lhs.org
Residents: OBGYN, Emergency Medicine; Salmon Creek Students Residents:	Krista Walker	kriwalke@lhs.org
Ophthalmology & OMFS; Fellow rotations at EMC/GSMC & Unity BHC:	DeeDee Bondy	dbondy@lhs.org
Medical /PA Students (except IM ICU/Wards); Residents: Peds Inpatient Residents:	Janet Mitchell	jcmitche@lhs.org
Surgery, Urology, Interventional Radiology, Unity BHC, Orthopedics:	Angela Cacchioli.....	acacchio@lhs.org

HOME INSTITUTION INFORMATION

This page to be completed by the trainee's Program Director or Dean

The trainees's home institution is responsible for verifying and maintaining evidence and documentation of the administrative requirements for each trainee as established under Oregon Administrative Rules 409-030-0100 and will provide Legacy Health with documentation of the below requirements upon request.

I attest, _____, does meet the below requirements for training at Legacy Health.
(print trainee name)

Is in good standing, qualified to do clinical rotations, and not on remediation or probation in their training/education program.	Yes No
Has documented proof of vaccinations (per CDC guidelines): Hepatitis B (Hep B), measles, mumps and rubella (MMR), tetanus, diphtheria, pertussis (Tdap), and varicella. Polio and influenza (seasonal flu) are recommended.	Yes No
Has documented proof of Tuberculosis (TB) screening in accordance with CDC guidelines.	Yes No
Has documented proof of 10-panel drug screen, which must include screens for the following eight substances: Amphetamines, including methamphetamines; Barbiturates; Benzodiazepines; Cocaine; Marijuana; Methadone; Opiates; Phencyclidine.	Yes No
Has documented proof of Criminal Background Check: Must include social security number trace, state/national criminal background history, sex offender registry check, and OIG LEIE check.	Yes No
Has documented proof of CPR/Basic Life Support (BLS) for healthcare providers. It is recommended that trainings comply with the American Heart Association standard.	Yes No
Is covered by professional liability insurance coverage and general liability insurance coverage, or a combined policy that includes professional and general liability coverage, valid in the State of Oregon, for a minimum of $1 million per occurrence and $3 million per aggregate. The coverage must remain in place for the entire duration of each placement. *Please provide proof*	Yes No
Has major medical insurance, valid in the State of Oregon, which will be in effect during the requested rotation.	Yes No
The trainee is a U.S. citizen or has a valid visa to work in the United States.	Yes No
For Residents and Fellows ONLY This trainee holds, or has applied for, an Oregon Medical License or dental permit (R2 level or higher).	Yes No

Name of Home Institution *(Please print)*

X

Signature of Program Director or Dean | Printed Name | Date