RESIDENT/FELLOW ROTATION APPLICATION

Current training type: ☐ RESIDENT ☐ FELLOW

DEMOGRAPHIC INFORMATION

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

Credential(s):_____ Primary Phone:_____ Email:_____

EMPLOYER INFORMATION

Employer:_____ Street Address:_____

City:_____ State:_____ Zip:_____

Contact Person:_____ Email Address:_____ Phone Number:_____

MEDICAL SCHOOL INFORMATION

Medical School:_____ Graduation Date:_____

RESIDENCY TRAINING INFORMATION

Initial Residency Program/Specialty:_____

Initial Residency Training Site:_____

Start Date:_____ End Date (or anticipated):_____

RESIDENTS

For the following questions, please consult your Medical Education staff to ensure accuracy:

Current Residency Program (if different from initial program):_____

Post Graduate Year:_____ Training Year in Current Program:_____

Please provide any off-cycle information (if applicable):

FELLOWS

For the following questions, please consult your Medical Education staff to ensure accuracy:

Residency Program you graduated from (if different from Initial Program):_____

Current Fellowship Program:_____

Post Graduate Year:_____ Training Year in Current Program:_____

Please provide any off-cycle information (if applicable):

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ROTATION REQUEST(S)

Single Rotation Application: ☐ Academic Year Rotation Application: ☐

Rotation Name:_____Start date:_____End date:_____

Rotation Name:_____Start date:_____End date:_____

Comments:

STATE LICENSURE OR TRAINING CERTIFICATE

Do you have a valid State of Ohio training certificate or medical license? ☐ YES ☐ NO

ADDITIONAL INFORMATION

For the following questions, please consult your program coordinator to ensure accuracy:

Will you be attending didactic sessions at your home program? ☐ YES ☐ NO
What are the date(s) & time(s) of your didactic session(s)

Will you be participating in any clinical activities at your home program? ☐ YES ☐ NO
What dates/times are your clinical activities?

Will you be taking call at your home institution? ☐ YES ☐ NO
What dates are you taking call?

Are you taking any vacation time during your rotation? ☐ YES ☐ NO
Please add your dates of vacation below:

DISCLOSURE

Are you aware of limitations which would prevent you from performing the duties of the rotation?

☐ YES ☐ NO

Have you ever been convicted of a felony?

☐ YES ☐ NO

Submit Applications to:
Matthew Rinear, B.S. C-TAGME
rinearm@summahealth.org
330-375-3791

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DOCUMENT CHECKLIST

Once your application has been approved, you will receive instructions to log into New Innovations and complete our onboarding process electronically. Please be prepared to submit the documents listed below in PDF format as part of this process. Photographs of documents will not be accepted.

Note that our onboarding process will require you to take additional steps outside of submitting documents. Those steps will be outlined in the checklist assigned to you in New Innovations.

- [ ] **Medical School Diploma**
  - Must be in English
- [ ] **Current Curriculum Vitae**
- [ ] **Valid Ohio Training Certificate or Medical License**
  - If you do not have an Ohio training license, you will need to apply for one. Refer to directions in New Innovations.
- [ ] **Immunization Record and/or Titers, to include:**
  - Tuberculosis screening (read between 1/1/2023 and 6/30/2023)
  - MMR (2 doses or positive titer)
  - Varicella (2 doses, history of illness, or positive titer)
  - COVID-19 (2 doses Moderna/Pfizer or 1 dose J&J)
  - Influenza (if rotating between November 1 and May 31)
  - TDAP (optional)
  - Hepatitis B (optional)
- [ ] **ECFMG Certificate (if applicable)**
- [ ] **Background Check Verification**
  - A letter from your medical education department verifying completion of a background check.

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