UNIVERSITY OF ARIZONA COLLEGE OF MEDICINE
VISITING RESIDENT APPLICATION FORM

Please allow 90-120 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): ______________________________

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☐ 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 Program Director Signature: ______________________________ Date: __________

Host Supervisor Signature: ______________________________ Date: __________

Revised 10/21/2015