

**PROVIDENCE SACRED HEART MEDICAL CENTER
SPOKANE TEACHING HEALTH CENTER
GRADUATE MEDICAL EDUCATION COMMITTEE**

VISITING RESIDENT ROTATIONS POLICIES AND APPLICATION FORMS

Introduction:

The Providence Sacred Heart Medical Center and Spokane Teaching Health Center Graduate Medical Education Committee (GMEC) oversees resident education within its participating institutions. Since participating residency programs receive requests for rotations by residents from outside programs, GMEC has developed this policy to define training prerequisites and application requirements to ensure not only a uniform application and screening process but also the expectations of what that training will involve.

Outline of the Visiting Resident Policy:

- 1) Visiting residents are those from other than Spokane-based residencies.
- 2) The application packet lists the prerequisites and documents needed before a decision can be made regarding granting a resident rotation within the medical center.
- 3) The Spokane residency program that is responsible for supervising the visiting resident will review the application and collect the necessary documents before submitting the packet for final approval by GMEC (see Table below).
- 4) If GMEC approves the visiting resident rotation, the Spokane residency program sponsoring that resident will notify the appropriate medical staff office(s) of the name of the visiting resident and the rotation dates. The original application form and documents will be stored with the sponsoring residency program.
- 5) The GMEC has the option of making the final decision regarding approval of the application.
- 6) Completion of resident evaluation forms is the responsibility of the sponsoring residency program supervising the visiting resident. A copy of the evaluation form should be kept in the offices of the sponsoring residency.
- 7) The ultimate responsibility for the quality and content of the training experience as well as the supervision of the visiting resident while on the rotation resides with the residency program sponsoring the visiting resident.

Table: Responsible residency program for review of applications for training in DMC or SHMC

Residency Program	Clerkship or Elective Requested
Family Medicine Residency Spokane	Family medicine, OB/Gyn, Pediatrics & Surgery
Internal Medicine Residency Spokane	ICU Sub-I, Medicine Ward Sub-I, Hem/Onc Outpt, Nephrol Inpatient & Infectious Disease Inpatient
Transitional Year Residency Spokane	Anesthesiology and Emergency Medicine
Radiology Residency Spokane	General Radiology
Psychiatry Residency Spokane	Adult Psychiatry Inpt & Outpt, Consultation Liaison Psychiatry

VISITING RESIDENT ROTATION FACT SHEET

To be eligible for consideration, the visiting resident must meet all of the following criteria:

- 1) Residents must have an M.D. or D.O. degree (or its equivalent)
- 2) Residents must be either U.S. citizens or have a valid U.S. visa. If the resident has valid U.S. visa, that visa must allow them work in a Spokane rotation away from their primary residency program.
- 3) International medical graduates must have a valid ECFMG certificate.
- 4) Residents must be in good standing in their program.
- 5) Residents must have malpractice/liability insurance coverage from their institutions or from other source. A minimum coverage of \$1 million per occurrence and \$3 million aggregate is required. Residents who do not have this level of malpractice insurance coverage will not be accepted for participation in clinical electives.
- 6) Residents must have completed a program on universal precautions within the last 18 months ensuring the appropriate handling of blood, tissues, and body fluids.
- 7) Residents must have completed their program's training module or course in HIPAA Compliance. The resident must submit a copy of a certificate or letter of completion with the application packet.
- 8) Residents must have personal health insurance coverage in effect while away from their school.
- 9) Residents must sign a form to have a routine criminal background check performed by the WSP to comply with a Washington State requirement for those working in hospitals.
- 10) Residents must comply with the following immunization policy:
 - PPD: within the past 12 month period. Converters: initial chest X-ray, isoniazid (INH) x 6 months.
 - Tetanus/Diphtheria: primary series plus TD booster within last 10 years.
 - MMR (Measles, Mumps, Rubella): 2 positive serologies or 2 doses of vaccine after 1968 (the last after 1979).
 - Hepatitis B: series of 3 inoculations and follow-up titer.
 - Polio: complete primary series of oral trivalent vaccine or IPV (injectable) plus booster after the age of 4.
 - Current flu shot (a yearly vaccine is required)

APPLICATION FOR VISITING RESIDENT ROTATION

It is expected that your clinical work will be part of the academic requirements for graduation from your own residency program. For this reason, it is essential that the authorization for taking a rotation at this institution be received from your Program Director. The application provides for this authorization, and for the required certifications and compliance documents.

Please read all instructions and the application carefully:

Please type your responses, complete Section I and have your residency program complete Section II and the certification. *At this time, we can only accept and process "paper" applications. We cannot accept faxed or e-mailed applications as we must have on file the original signatures from your residency program. Please send one-sided copies only. Paper-clip all materials together, do not staple. All sections must be completed in order to avoid delay in processing.*

Section I (to be completed by the Resident)

Last Name: _____ First Name: _____ MI: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ E-mail: _____
SSN: _____ Birth Date: _____ Gender: _____

Residency
Program: _____

REQUESTED DATES

REQUESTED RESIDENCY PROGRAM(S)

- 1)
- 2)
- 3)

Are you interested in housing? Yes ____ No ____

Conditions and Responsibilities Residents are required to adhere to the standards, policies, and regulations of the sponsoring residency program and/or medical center(s) to which they are assigned for their clinical training.

The residency program and/or medical center has the right to take immediate action to correct a situation where a visiting resident's actions either endanger patient care or are deemed to be unprofessional or unethical. As soon as possible, the residency program sponsoring the resident will notify the visiting resident's program of the action taken. All final resolutions of the visiting resident's academic status in such situations will be made solely by the visiting resident's program. However, in these situations, the sponsoring residency program and/or medical center reserves the right to terminate the visiting resident rotation immediately.

By signing this section, the visiting resident verifies that he/she has read and agrees to the conditions and responsibilities.

Resident's Signature Date

Section II (to be completed and certified by Program Director for Visiting Resident)

(Any Yes answer to questions 1-7 requires explanation on a separate sheet of paper)

- 1) Was this resident ever subject to or considered for disciplinary action or probation? Yes ___ No ___
 - 2) Did this resident ever attempt procedures beyond his or her skill or level of training? Yes ___ No ___
 - 3) Did the resident ever attend patients while apparently under the influence of drugs, alcohol or controlled substances? Yes ___ No ___
 - 4) Did the resident ever have any medical problems or mental disorders that impeded or may have impeded their ability to practice medicine in a reasonable, safe and skillful manner? Yes ___ No ___
 - 5) Was the resident's status and/or clinical privileges ever revoked, suspended, reduced, restricted, not renewed or was he/she placed on probationary status or reprimanded at any time? Yes ___ No ___
 - 6) Are you aware of any pending professional medical misconduct, malpractice action or any findings of professional misconduct in your state or any other state regarding this resident physician? Yes ___ No ___
 - 7) Has the resident completed a documented medical program on universal precautions during the last 18 months ensuring appropriate handling of blood, tissues, and body fluids? Yes ___ No ___
 - 8) Is personal health insurance coverage in effect while away from your program? Yes ___ No ___
- Amount per claim or occurrence: \$ _____
 - The insurance carrier is: _____
 - Incidents should be reported to: _____ (Name) _____ (Phone)

Note: Your residency program must send us its goals, objectives and evaluation forms with this application for each rotation to be taken by the resident.

Signature _____ Date: _____

Name _____ Title: _____

School _____ PROGRAM SEAL (imprint)

Address _____

Phone _____

E-mail _____

Documents Required

- 1) Photograph (for identification purposes)
- 2) The residency program goals, objectives and evaluation forms for each rotation to be taken
- 3) Proof of malpractice coverage
- 4) Proof of completion of the school-sponsored training module or course in HIPAA compliance
- 5) Proof of health insurance coverage
- 6) Proof of immunization:
 - *PPD*: within the past 12 month period. *PPD* Converters: initial chest X-ray, isoniazid (INH) x 6 months.
 - *Tetanus/Diphtheria*: primary series plus TD booster within last 10 years.
 - *MMR* (Measles, Mumps, Rubella): 2 positive serologies or 2 doses of vaccine after 1968 (the last after 1979).
 - *Hepatitis B*: series of 3 inoculations and follow-up titer. *Polio*: complete primary series of oral trivalent vaccine or IPV (injectable) plus booster after the age of 4.
- 7) Copy of valid U.S. Visa and ECFMG certificate (if applicable)