



FLORIDA HOSPITAL GRADUATE MEDICAL EDUCATION

2501 North Orange Avenue – Suite 235 – Orlando Florida 32804 Website: www.fhgme.com

APPLICATION FOR TRAINING PRIVILEGES Please Type. Handwritten and / or Incomplete Applications will not be accepted.

APPLICANT STATUS			
<input type="checkbox"/> Pre-Med	<input type="checkbox"/> Medical Student	<input type="checkbox"/> Resident	<input type="checkbox"/> Other

TRAINING LEVEL			
<input type="checkbox"/> Clerkship	<input type="checkbox"/> Research	<input type="checkbox"/> Outpatient	<input type="checkbox"/> Assisting Privileges

APPLICANT INFORMATION							
Last Name			First		M.I.	Date	
Street Address			City		State	Zip	Apartment/Unit #
Gender <input type="checkbox"/> M <input type="checkbox"/> F		Date of Birth		Social Security No.			
School or Program Name				Graduation Date			
Home Phone				Mobile Phone			
E-mail Address			Emergency Contact			Phone	

TRAINING REQUEST		
Service/Department	Start Date	End Date
Service/Department	Start Date	End Date

FLORIDA HOSPITAL PRECEPTOR (IF APPLICABLE)			
Last Name		First	M.I.
			<input type="checkbox"/> MD <input type="checkbox"/> DO

HOUSING REQUEST
Will you require housing? <input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, \$50.00 Security Deposit must be included with the required documents. No cash please. We can only accept a check or money order made payable to Florida Hospital GME (\$200.00 per four week clerkship). Rental fee is due at orientation.

TRAINING STATEMENT
Are you aware of any limitations that would prevent you from performing the duties required for the training you are requesting?
<input type="checkbox"/> No <input type="checkbox"/> Yes Please explain:

REQUIRED DOCUMENTATION (IF APPROVED ALL DOCUMENTS MUST BE SUBMITTED TO THE GME OFFICE TWO WEEKS PRIOR TO SCHEDULED ARRIVAL)	
<input type="checkbox"/> LETTER OF GOOD STANDING	<input type="checkbox"/> CERTIFICATE - RESPIRATORY MASK FIT SIZE
<input type="checkbox"/> BACKGROUND SECURITY CHECK	<input type="checkbox"/> PHYSICIAN/STUDENT COMPUTER ACCESS FORM - CAA
<input type="checkbox"/> PROOF OF PERSONAL HEALTH INSURANCE	<input type="checkbox"/> HOUSING DEPOSIT (if applicable)
<input type="checkbox"/> PROOF OF MALPRACTICE LIABILITY INSURANCE	<input type="checkbox"/> COPY OF MEDICAL LICENSE (Residents Only)
<input type="checkbox"/> PROOF OF IMMUNIZATIONS - PPD within 12 Months (annually) - MMR Vaccination - Varicella Vaccination or Immunity and Hepatitis B (If refused, you must provide a signed waiver)	

PROGRAM INFORMATION OFFICIAL DESIGNATED TO RECEIVE CORRESPONDENCE/ EVALUATION

School/ Program Name				Title	
Last Name		First		<input type="checkbox"/> MD	<input type="checkbox"/> DO
Street Address		City	State	Zip	Suite/Unit #
Business Phone			Business Fax		
Email					

DISCLAIMER AND SIGNATURE

I certify that my answers are true and complete to the best of my knowledge. If this application is approved, I understand that I am responsible for submitting all required documents.

Signature	Date
Signature of Program Director (Residents Only)	Date

APPROVAL DATES

Service/Dept.	Start Date	End Date
Service/Dept.	Start Date	End Date

PRECEPTOR STATEMENT (PLEASE PRINT)

The applicant has a valid Florida Medical License. No Yes Please provide the License Number _____

As a member of the Medical Staff with appropriate privileges for procedures. I endorse the applicant to complete the approved rotations at Florida Hospital. This applicant will be under my full supervision. This applicant is in Good Standing and covered by Malpractice Liability Insurance through their medical program.

Last Name		First		M.I.	<input type="checkbox"/> MD	<input type="checkbox"/> DO
Street Address		City	State	Zip	Suite/Unit #	
Business Phone			Business Fax			
Mobile Phone			Email			
Signature, Preceptor					Date	

DEPARTMENT OF GRADUATE MEDICAL EDUCATION (FOR GME USE ONLY)

The applicant is:	<input type="checkbox"/> Approved	<input type="checkbox"/> Declined	
The applicant may:	<input type="checkbox"/> Assist Preceptor		
Signature, Supervising Faculty/ Residency Coordinator			Date
Signature, GME Representative			Date

Submit Documentation to: Florida Hospital Graduate Medical Education
 Attention: GME Coordinator
 2501 North Orange Avenue, Suite 235 Orlando, Florida 32804
 E-mail: FH.GME.Coordinator@flhosp.org
 Phone: 407.303.5270
 Fax: 407.303.5273