



FLORIDA HOSPITAL GRADUATE MEDICAL EDUCATION

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

Visitor Registration Please Type.

REQUIRED DOCUMENTATION (PLEASE ATTACH THE FOLLOWING DOCUMENTATION WITH THIS APPLICATION)

Photo for Proof of Identification

APPLICANT INFORMATION

Last Name	First	M.I.	Gender	<input type="checkbox"/> M	<input type="checkbox"/> F
Address	City	State	Zip	Suite/Unit #	
Home Phone	Email				
Emergency Contact	Relationship	Contact Number			

CONFIDENTIALITY STATEMENT

I understand that any inappropriate retrieval, review and or sharing of patient or employee information with unauthorized individuals is considered a breach of confidentiality and may result in the termination of visiting privileges in accordance with Florida Hospital policy.
I understand my responsibilities and obligations under this policy and my signature below is my acknowledgement to adhere to its terms.

Signature, Applicant

Date

PHYSICIAN'S INFORMATION

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

APPROVAL DATES

Start Date	End Date
Signature, Physician	Date

DEPARTMENT OF GRADUATE MEDICAL EDUCATION (FOR GME USE ONLY)

This Application is:	<input type="checkbox"/> Approved	<input type="checkbox"/> Declined
Signature, Florida Hospital Representative	Date	

Please submit documentation to the appropriate Residency Program Coordinator or Physician