

BAYLOR COLLEGE OF MEDICINE AFFILIATED HOSPITALS RESIDENCY PROGRAM

APPLICATION FOR VISITING HOUSE STAFF

To be completed by resident or postdoctoral fellow applying for elective:

Specialty / subspecialty where you desire to rotate: _____ Inclusive dates of rotation:
From _____ To _____

Name _____
(Last) (First) (Middle) (Title)

Mailing address _____

Birth date _____ Place of birth _____ Citizenship _____

If not a US citizen, indicate visa type _____ Visa sponsor _____

Date of entry into US _____

Current Training Program:

(Address)

(City) (State) (Zip code)

Current Specialty _____ Year _____ PGY _____

If applicable, enter current Texas medical license # _____, Postgraduate resident permit# _____,
Institutional permit # _____

Issue date _____ Expiration date: _____

Medical School attended _____ Date of Graduation _____

***** If a graduate of a foreign medical school, attach a notarized copy of your ECFMG certificate*****

Do you have any medical conditions that might impair your participation in the program? If so, please describe.

I certify that the above information is accurate. I am aware that, unless already registered with the Texas State Board of Medical Examiners, I must apply directly to that agency for a postgraduate resident permit and pay their fee. I understand that I must arrange with Baylor for malpractice insurance during this rotation if my current coverage does not remain in effect or meet Baylor's minimum acceptable amounts of coverage. I understand I must satisfy Baylor requirements for immunizations and occupational health screening and carry personal health insurance throughout this elective if my current program will not insure me.

Signature _____ Date _____

To be completed by the director of the training program in which the house officer is currently enrolled:

The house officer listed on the reverse side:	YES	NO
Is in good standing in our program	_____	_____
Is approved to take this elective rotation at Baylor College of Medicine	_____	_____
Is covered by our program for Malpractice insurance with minimum acceptable coverages of: \$1,000,000 per occurrence / \$3,000,000 in the aggregate*	_____	_____
Is covered by our program for Health Insurance: (If "No", house officer should attach proof of any personal health insurance**)	_____	_____

Name and Title: _____

Signature: _____ Date: _____

* If yes, attach a copy of the certificate of insurance

** a copy of the policy including the house officer's name, a medical identification card, or a letter from the insurance company.

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This section to be completed by the Baylor department providing the elective:

Approved: _____ (Chairman or Designee Signature)	Disapproved: _____ (Chairman or Designee Signature)
Date: _____	Date: _____

The house officer should report to:

Person: _____ Date: _____

Location: _____ Room Number _____

House officer will rotate at this hospital(s): _____

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To be completed by the Office of Graduate Medical Education, Baylor College of Medicine:

Malpractice insurance \$ _____

Signature: _____ Date: _____

Remarks: _____

Please mail this completed form to:

Baylor College of Medicine
Division of Cardiovascular Anesthesiology
Texas Heart Institute at St. Luke's Episcopal Hospital
c/o Patricia Carpenter
P.O. Box 20345, MC 1-226
Houston, TX 77225-0345

Phone: 832-355-2202

Fax: 832-355-6500

E-mail: pcarpenter@heart.thi.tmc.edu