Ascension Macomb-Oakland Hospital

Ascension Macomb-Oakland Hospital Graduate Medical Education In-Rotator Request Form

Instructions:

1. In-Rotator please forward to the Ascension Macomb-Oakland Program Coordinator, this **In-Rotator request** (Retain a copy of this request for your file)
2. **AMOH Coordinator**: Please submit the request with signature of approval no later than **60-Days** prior to the rotation start date to amohgme@ascension.org

Rotation/Service Requested: _____

Rotation Dates _____ **to** _____

Applicant Name: _____ **MD** ☐ **DO** ☐ **DDS** ☐ **DPM** ____

Resident ☐ **Fellow** ☐ **Male** _____ **Female** _____ **DOB** _____ **Social Security #:** _____

NPI: _____ **DEA#:** _____ **ECFMG#**_____

Phone #: _____ **Email:** _____

Applicant Home Institution (Hospital) _____ **Current PGY:** _____

Current residency/fellowship Program: _____ **Current program Start Date:** _____

Initial Program: ☐ **Yes** ☐ **NO** **If No, initial program:** _____

Initial Program Dates: (MM/DD/YY) _____ **to (MM/DD/YY)** _____

Medical School:)_____ **Year Graduated: (MM/DD/YY)** _____

Applicants Home Institution Coordinator Name: _____

Coordinator Email: _____**Phone:** _____

Should notice go to the coordinator's email: ☐ **Yes** ☐ **NO**

AMOH Program Approval (Tentative approval pending completed application)

Program Director/Coordinator Printed Name: _____**Email:** _____

Program Director/Coordinator Signature: _____ **Date:** _____

For Administration use ONLY: NI Username: _____ Password: _____

Checklist due: _____ Checklist Complete: ____ PLA ____ Credentialing Requested: ☐ Credentialed: _____

Dictation Requested ☐ Dictation #_____ IT Access: _____ Badging _____

Applicant return the completed Rotation Request form to the Rotation Specific AMOH GME Program Coordinator, for Approval