



Graduate Medical Education

Visiting Trainee Rotation Request Form

Legacy GME requires 30-days to process all requests

Visiting Trainee Information:

Last Name: _____ First Name: _____ Middle Initial: _____
legal name legal name

DOB: _____ SS#: _____ Gender: _____
(mm/dd/yyyy) (xxx-xx-xxxx)

Cell: _____ Pager: _____ Email: _____
(xxx-xxx-xxxx) If applicable

Home Institution: _____

Institution Address: _____

Institution Coordinator: _____ Coordinator Email: _____ Coordinator Phone: _____
(xxx-xxx-xxxx)

Trainee Current Program Program End
 Type: _____ Year: _____ Date: _____
(mm/dd/yyyy)

Rotation Information:

Legacy Rotation: _____ Legacy Preceptor: _____

Legacy Rotation Site(s): Emanuel Good Samaritan Meridian Park Mt Hood Salmon Creek Silverton Unity LMG Clinic

Rotation Start: _____ Rotation End: _____ Prior Epic Experience: YES NO

Residents & Fellows:

Degree: _____ Speciality: _____ PG Year: _____

Medical and/or Dental School: _____ Graduation Date: _____
(mm/dd/yyyy)

NPI#: _____ Medical License #: _____ Expiration Date: _____

For Internal Medicine Student Rotations ONLY - one rotation, per student, per academic year

Audition Rotation: YES NO USMLE/Complex Step 1* _____ Step 2* _____

**a transcript copy may be requested prior to approval*

Trainee required remediation and/or failed a clinical course rotation: YES NO

Trainee is in good standing and is qualified to do a clinical rotation: YES NO

Future Plans? _____

PLEASE RETURN YOUR COMPLETED FORM TO:

QUESTIONS:

LEMC/LGSMC Internal Medicine ICU/Wards; Pulm/Critical Care Medicine/Geriatric Medicine.

Traci Aul

taul@lhs.org

Phone: (503) 413-7590

LGSMC General Surgery, Anesthesia, Gyn Onc, MIS, MIGS, Hepatobiliary, Nephrology, Bariatrics, Ophthalmology

Diane Sawyer

dsawyer@lhs.org

Phone: (503) 413-7529

LEMC/LGSM: Adult & Peds Emergency Medicine, LEMC OBGYN

Angela Cacchioli

acacchio@lhs.org

Phone: (503) 413-4656

LEMC: General Surgery, Ortho, Peds Ortho Trauma, Anesthesia, Ophthalmology, OMFS. Unity Psychiatric.

DeeDee Bondy

dbondy@lhs.org

Phone: (503) 413-4692

Medical/PA Students: Burn, GoHealth, IM Subspecialties, Neurology, OBGYN, Peds, Trauma, Unity Psych, Electives, Preceptorships. Peds Residents. Hospice Fellows.

Janet Mitchell

jmitche@lhs.org

Phone: (503) 413-2737



HOME INSTITUTION INFORMATION

This page to be completed by the trainee's Program Director or Dean

The trainees's home institution is responsible for verifying and maintaining evidence and documentation of the administrative requirements for each trainee as established under Oregon Administrative Rules 409-030-0100 and will provide Legacy Health with documentation of the below requirements upon request.

I attest, _____, does meet the below requirements for training at Legacy Health.
(print trainee name)

Is in good standing, qualified to do clinical rotations, and not on remediation or probation in their training/education program.	Yes	No
Has documented proof of vaccinations (per CDC guidelines): Hepatitis B (Hep B), measles, mumps and rubella (MMR), tetanus, diphtheria, pertussis (Tdap), and varicella. Polio and influenza (seasonal flu) are recommended.	Yes	No
Has documented proof of Tuberculosis (TB) screening in accordance with CDC guidelines.	Yes	No
Has documented proof of 10-panel drug screen, which must include screens for the following eight substances: Amphetamines, including methamphetamines; Barbiturates; Benzodiazepines; Cocaine; Marijuana; Methadone; Opiates; Phencyclidine.	Yes	No
Has documented proof of Criminal Background Check: Must include social security number trace, state/national criminal background history, sex offender registry check, and OIG LEIE check.	Yes	No
Has documented proof of CPR/Basic Life Support (BLS) for healthcare providers. It is recommended that trainings comply with the American Heart Association standard.	Yes	No
Is covered by professional liability insurance coverage and general liability insurance coverage, or a combined policy that includes professional and general liability coverage, valid in the State of Oregon, for a minimum of \$1 million per occurrence and \$3 million per aggregate. The coverage must remain in place for the entire duration of each placement. <i>Please provide proof</i>	Yes	No
Has major medical insurance, valid in the State of Oregon, which will be in effect during the requested rotation.	Yes	No
The trainee is a U.S. citizen or has a valid visa to work in the United States.	Yes	No
<i>For Residents and Fellows ONLY</i> This trainee holds, or has applied for, an Oregon Medical License or dental permit (R2 level or higher).	Yes	No

Name of Home Institution *(Please print)*

X _____

Signature of Program Director or Dean

Printed Name

Date