Rev. 10/08

YALE-NEW HAVEN HOSPITAL
APPLICATION FOR SHORT-TERM ROTATION

☐DB ☐Iris ☐MB
Clinic Days_____
☐Scanned

The Employing Institution must (1) hold a Permit to Practice Medicine in Connecticut for the Resident, (2) Submit proof of malpractice coverage with each application. (3) Submit a copy of the resident's Medical School Diploma. (4) Submit an up-to-date CV. (5) Submit a copy of a valid ECFMG Certificate for graduates of foreign medical schools. (6) Complete all Sections. (7) Mail to the appropriate YNHH department prior to the residents arrival. Please call Heather Russell-Milici or Cheryl Guliuzza at (203) 688-2259 or e mail Cherylann.Guliuzza@ynhh.org or Heather.Russell-Milici@ynhh.org. **FORMS MUST BE SIGNED BY THE APPROPRIATE YALE-NEW HAVEN HOSPITAL CHIEF OF SERVICE.**

Name: _____ NPI Number: _____
(Last Name) (First Name) (Middle Name)
Social Security #: _____ Date of Birth: _____ Sex: __ Race: ____ E-mail: _____

Name of **current residency training program**: (i.e. Medicine, Pediatrics, Med/Peds) _____
PGY Level **at the time of** Rotation at YNHH: _____ Is this a preliminary year? Yes ☐ No ☐
If yes, what residency training program will you be entering after your preliminary year(s)? _____
If you were in the NRMP (National Residency Matching Program), what program (**not Hospital**) did you match for?
_____

Department: _____

Section: _____ From: _____ To: _____

Section: _____ From: _____ To: _____

Section: _____ From: _____ To: _____

Section: _____ From: _____ To: _____

Medical School: _____ Degree: _____

Graduation Date: _____ Foreign Medical Graduate ☐ Yes ☐ No ECFMG Issue Date: _____
MM/DD/YYYY MM/DD/YYYY

For Foreign Medical Graduates: Application will not be accepted without copy of ECFMG Certificate

Internship, residency, fellowship training: (Note clinical or research) **U.S. and Canadian appointments Only**. Name of Training program (i.e. medicine, pediatrics, surgery, etc.)	PGY Level	Hospital	Appointment Dates From:	To:

References:
Name of Current Dept. Chief: _____ Dept. Contact Person: _____ Contact E-mail: _____

Name of Current Department (Not YNHH) _____ Hospital: _____

Dept. Telephone # _____ Dept. Fax # _____

Resident's Signature: _____ Date: _____

Chief of Service Signature _____ Date: _____
Yale-New Haven Hospital