



MOUNT CARMEL

ROTATION APPLICATION

Name _____
Last First MI

Residency Program _____
City/State Graduation Date

ROTATION REQUESTED

Specialty _____ From _____ to _____

If this rotation is not available during the dates given, please indicate alternate rotation.

Alternate _____ From _____ to _____

Present Address Permanent Address (if different)

Phone () _____ Phone () _____

Email address _____

Please send correspondence to my _____ present address _____ permanent address.

Upon receipt of this application and written verification from your residency program of professional liability insurance and good standing, we will process your request. If we are able to accommodate your primary or alternate request, we'll send you a confirmation and information packet within 4 weeks. If we cannot accommodate your request, we will notify you by e-mail immediately.

Be sure to have the appropriate residency program official complete the second page of this application.

Resident Signature _____ Date _____

The Resident should e-mail completed application to:
medresmeded@mchs.com

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To be completed by residency program official

This resident physician is in good standing and has approval to schedule the rotation or alternate rotation listed on the reverse side of this application.

Signature of authorized official & title

Date

Printed name of residency program

Telephone number

Address of program

The appropriate residency program official should either mail or fax this form to Mount Carmel Medical Education.

You may mail this form to:

Mount Carmel Medical Education
793 W. State Street
Columbus, Ohio 43222

Or, you may fax this form to:

(614)234-2772