

**MEDICAL UNIVERSITY OF SOUTH CAROLINA - GRADUATE MEDICAL EDUCATION
VISITING RESIDENT INFORMATION/SIGNATURE FORM**

Name of Resident:

Application for Rotation in (Name of Department and Program):

Program Director:

Begin Rotation On:

End Rotation On:

Clinical Rotation Supervising Attending:

Resident's Home Address:

Resident's Home Phone Number:

Resident's Work Phone Number:

Resident's Email Address:

In Case of Emergency, Notify:

Phone Number:

Sponsoring (Home) Institution:

Residency Program:

Residency Program Director:

Residency Program Phone Number:

Year in Program:

Malpractice Insurance Carrier:

Policy Number:

Dates of Coverage:

SC Medical License Number:

Expiration:

Federal NPI Number:

EPIC 8-hour Classroom Training Clearance Signature and Date:

Employee Health Services Clearance Signature and Date:

Verification of Criminal Background Check Clearance (**Human Resources Signature**) and Date:

MyQuest Lessons Clearance (**GME Office Signature**) and Date:

E*Value Profile Creation Verification (**GME Office Signature**) and Date:

MUSC Patient Safety Brochure Orientation Verification (**MUSC Program Director Signature**) and Date:

Signature of Visiting Resident and Date: