

**Application for Temporary Rotation as a Resident/Fellow at the
University of Tennessee Medical Center and the
Graduate School of Medicine, Knoxville TN**

I hereby apply for a residency/clinical fellow training rotation in the Department of:

Name of elective _____

Date elective begins _____

Date elective ends _____

Last Name _____ First _____ Middle _____

Present Address _____ City _____ State _____

Phone Number _____ Email _____

Graduate of Medical/Dental School _____

Degree received MD DO DMD DDS Other _____

Current Training Program Name _____ PGY _____

Current Training Program Location _____

Currently training as a resident/fellow in Tennessee Yes No*

*If not training in TN, you will be issued at your expense a TN licensure exemption, charge \$10 M.D., \$50 D.O., OMFS and Dentistry do not require a licensure exemption.

Medical Liability Insurance Carrier _____

Limits of coverage in \$ Minimum _____ Total _____ (minimum. \$1 million/3 million)

Coverage extends to an out-of-state elective? Yes No TN applicant

Have you had any cancellations, non-renewals or limits placed on your liability coverage? Yes No

Have you been party to any liability claims, suits or settlements? Yes No

Health Insurance Coverage Provider _____

Insurance coverage extends to an out-of-state elective (specifically TN)? Yes No TN applicant

Applicant

By accepting this temporary assignment to the Housestaff at the University of Tennessee Medical Center and the Graduate School of Medicine, I agree to abide by the rules and regulations of the medical center and the GSM. I understand that the UT will not provide me with a stipend, professional liability or health insurance coverage during this elective.

Signature _____

Date _____

Applicant's Program Director

This resident/fellow is in good standing and has no history of disciplinary actions in our program. The information the applicant provided above is correct. This elective will be beneficial to the resident's education. Our institution will provide the stipend, medical liability coverage, and health insurance coverage for this resident during the elective.

Printed Name of PD _____

Signature of PD _____

Date _____

PD Phone _____ PD email _____

UTMC/GSM Program Director

I have reviewed this application and approve this resident for an elective in our program. I have discussed this elective with the applicant and if warranted with the program director.

Printed Name of PD _____

Signature of PD _____

Date _____

DIO at UTMC/GSM _____

Date _____

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