

Mail to  
Graduate Medical/Medical Student Education Department  
**CLEVELAND CLINIC FLORIDA**  
2950 Cleveland Clinic Boulevard  
Weston, Florida 33331  
Phone: 954/659-5229  
Fax: 954/659-5622  
Toll Free Number: 1-866-293-7866 ext. 56211

**APPLICATION FOR VISITING RESIDENT**  
Please Print or Type

**APPLICATION FOR:** \_\_\_\_\_ **Dates:** \_\_\_\_\_

\_\_\_\_\_ **Service/Department** \_\_\_\_\_ **From** \_\_\_\_\_ **To** \_\_\_\_\_  
**PGY LEVEL** \_\_\_\_\_ **NPI #** \_\_\_\_\_

Have you been a visiting observer at Cleveland Clinic Florida before? ☐ Yes ☐ No

\_\_\_\_\_  
Last Name First Name Middle Name Social Security Number

\_\_\_\_\_  
Present Mailing Address (Street, City, State, Country, Postal Code)

\_\_\_\_\_  
Permanent Mailing Address (Street, City, State, Country, Postal Code) Date of Birth Place of Birth

\_\_\_\_\_  
Area Code/Home Phone Number Area Code/Work Phone Number Area Code/Fax Number E-mail address

**EDUCATION - Name and Location of School - Dates of Attendance and Degree Obtained**

Medical Degree (School, Location, Date of Graduation- month -day- year) **PLEASE SUBMIT A COPY OF YOUR MEDICAL SCHOOL DIPLOMA**

\_\_\_\_\_  
Residency (Specialty & Graduate Level, Hospital, Location, Date of Completion, month date and year s)

**LIST OTHER ADVANCED APPOINTMENTS INCLUDING CURRENT ONE (HOSPITAL, LOCATION, DATE):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Please attach a copy of your curriculum vitae.

**HEALTH REQUIREMENTS:**

Visitors are required to provide proof of immunizations, specifically:

1. Varicella, Rubella, Titers, and/or proof of immunizations, specifically:
2. Recent documents TST test or recent chest x-ray (<1year) if known TST positive
3. Proof of hepatitis B immunity (serology)
4. Proof of bloodborne pathogen training or training will be provided prior to starting rotation

DO YOU HAVE A FLORIDA MEDICAL LICENSE NUMBER? IF YES, PLEASE SUBMIT A COPY OF YOUR MEDICAL LICENSE. ☐ No

☐ Yes Number: \_\_\_\_\_ Permanent: \_\_\_\_\_ Training Certificate: \_\_\_\_\_

Are you aware of any limitation that would prevent you from performing the duties of the training position for which you are applying?

☐ No

☐ Yes

Explain: \_\_\_\_\_

DO YOU HAVE A NARCOTIC REGISTRY LICENSE IN FLORIDA (DEA)? IF YES, PLEASE SUBMIT A COPY OF YOUR DEA CERTIFICATE. ☐ No

☐ Yes DEA Number: \_\_\_\_\_

Are you a citizen of the United States? ☐ Yes ☐ No Type of Visa: \_\_\_\_\_ ( please submit a copy of visa)

**INTERNATIONAL MEDICAL GRADUATES ONLY:**

Are you certified by the Educational Commission for Foreign Medical Graduates (ECFMG)?

☐ No ☐ Yes Certificate number \_\_\_\_\_ Certification valid through date: \_\_\_\_\_  
Examination Taken

VQE 1 \_\_\_\_\_ 2 \_\_\_\_\_

NBME 1 \_\_\_\_\_ 2 \_\_\_\_\_

FMGEMS 1 \_\_\_\_\_ 2 \_\_\_\_\_

USMLE 1 \_\_\_\_\_ 2 \_\_\_\_\_

**PLEASE SUBMIT A COPY OF YOUR CURRENT VALID ECFMG CERTIFICATE.**

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**I certify that the information given on this form is true, accurate and complete.**

\_\_\_\_\_  
Signature of Applicant Date \_\_\_\_\_

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***FOR CLEVELAND CLINIC FLORIDA USE ONLY:***

**Approved by:**

\_\_\_\_\_  
Department Program Director or Supervising Physician

\_\_\_\_\_  
Chairman, Graduate Medical Education Committee