KAISER PERMANENTE®

VISITING RESIDENT REGISTRATION

Legal First Name:	Middle Name:	Legal Last Name:
Home Institution:	**Program / Specialty:**	**Program Director:**
Institution Start Date:	**Expected Grad Date:**	**Current PGY:**

Has the trainee previously rotated at any Kaiser Permanente Northern California hospital? ☐ Yes ☐ No

If yes, required documentation may only be required if resident rotated in the previous academic year.

KAISER PERMANTE NORTHERN CALIFORNIA ROTATIONS

FROM (mm/dd/yyyy)	**TO** (mm/dd/yyyy)	**KPNC FACILITY**	**SPECIALTY / ROTATION**	% of Rotation at Kaiser Facility

REQUIRED DOCUMENTATION

- ☐ **Resident Demographic Information, Medical School and Postgraduate Training** (pg 2)
- ☐ **Home Program Master Rotation Schedule**
- ☐ **Clinic or Shift Schedules** (if resident will be at Kaiser less than 100% of rotation block)
- ☐ **Current Curriculum Vitae**
- ☐ **Signed Copy of Current Residency Contract**
- ☐ **Copy of Medical School Diploma** (if unlicensed)
- ☐ **Copy of CA Medical License** (if applicable)
- ☐ **Copy of ECFMG Certificate** (if applicable)
- ☐ **Photo Identification**
- ☐ **Proof of Immunizations/Titers and Current PPD Result**
- ☐ **Confidentiality Agreement (2870)**
- ☐ **Abuse Reporting Requirements (2860)**
- ☐ **Elder and Dependent Adult Abuse Reporting Requirements (2950)**
- ☐ **Guidelines for Standard/Universal Precautions Against Exposure to Bloodborne Pathogens**
- ☐ **Compliance Training Certificate of Completion** (Principles of Responsibility/HIPAA/Safety)
- ☐ **Drug-Free Workplace Policy**
- ☐ **National Social Media Policy**

REQUIRED SIGNATURES

☐ I attest that the rotations listed above are authorized and the information provided within this document is true and correct to the best of my knowledge.

Resident Signature:	Date:
Home Program Administrator Signature:	Date:

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RESIDENT DEMOGRAPHIC INFORMATION

Please fill out this form completely and attach all required documentation for submission to the applicable Kaiser Permanente GME Office(s) **at least 60 days prior to the start date of the rotation(s)**.

Legal First Name:	Middle Name:	Legal Last Name:
Maiden Name:	Preferred Name:	
Degree(s):	SSN:	Date of Birth:

Citizenship:	Ethnicity:	Language(s):	Gender:

Current address:

Affiliate School Email address:

Home Phone:	Cell Phone:	Pager:

Emergency Contact (name, phone, relationship):

CA Medical License:	Expires:
ECFMG License:	Issued:
DEA License:	Issue Date: / Expires:

National Provider Identifier (NPI):

MEDICAL SCHOOL INFORMATION

Medical School Name: Foreign School ☐

City/State/Country:	Graduation Date:	Degree:

POSTGRADUATE TRAINING

List **all years** of postgraduate training, employment, and time off since receiving a medical degree.
Please account for every academic year since medical school graduation, with no gaps.

If you are a **preliminary** resident, identify the program you are matched to start next year:

FROM (mm/dd/yyyy)	TO (mm/dd/yyyy)	TRAINING PROGRAM (PGY) / OTHER ACTIVITY	LOCATION