

**WELLMONT HEALTH SYSTEM
OSTEOPATHIC FAMILY MEDICINE RESIDENCY PROGRAM
VISITING RESIDENT APPLICATION**

Section 1: To be completed by Visiting Resident.

Name: _____ **Social Security #:** _____

Date of Birth: _____ **Degree:** _____ **Medical School:** _____

***Medical License #:** _____ **State:** _____ **Exp. Date:** _____

Current Program Name: _____

Program Address: _____

Current PGY Level: _____ **Current Program Director:** _____

Please list all post-graduate training. Include all training program dates and residencies:

1. _____
2. _____
3. _____

Home Address: _____

Phone: _____ **E-Mail:** _____

Rotation: _____ **Start Date:** _____ **End Date:** _____

Section 2: To be completed by Visiting Resident's Department Chair or Program Director.

I approve the above rotation and verify that this resident will continue to be paid by _____ **during his/her rotation at WHS and *malpractice insurance will be provided**
by _____ **and will cover his/her activities at WHS. *Virginia malpractice cover is**
\$2m/\$6m.

Chairman/Program Director

Signature and Date

Section 3: To be completed by WHS Residency Program

Approved _____

Disapproved _____

DME or Designee

Signature and Date

Attachments: Copy of Medical or Training Licenses.

Submit Completed Application and Attachments to: Wellmont Health System, Office of Medical Education, Cloverleaf Square, Ste. F1, Big Stone Gap, VA 24219