Application for Elective Rotation in Sports Medicine
Geisinger Health System
Primary Care Sports Medicine Fellowship
TO BE ELIGIBLE YOU MUST:

1) Be a resident currently in good standing at an ACGME or AOA accredited residency in emergency medicine, family medicine, internal medicine or pediatrics.

2) Submit verification of completion of core rotations in residency of at least 12 months duration. No elective rotation will be approved for sports medicine if prerequisite core clinical experience at the home institution will not have been satisfactorily completed prior to the start of the requested rotation. Refer to Section II below.

3) Attach documentation to the effect that you are covered by medical liability/malpractice insurance and personal health insurance; immunizations (using employee health form) are current and complete; and bloodborne/airborne pathogens training has been completed during the current academic year. The applicant must document their training in HIPPA and patient confidentiality. This information should be readily available from **YOUR** program house staff coordinator. Geisinger Health System may be able to provide HIPPA & confidentiality training if necessary. Please contact Scott Jenkins at address listed below if this training is needed.

4) Specify desired period of rotation of 1 month and location. STATE YOUR PREFERENCES FOR WHICH CAMPUS OF GEISINGER HEALTH SYSTEM YOU PREFER TO TRAIN. Presently sports medicine fellowship training occurs only at the GWV campus while electives are open in Danville-GMC and Wilkes-Barre-GWV.

5) If the applicant is a resident in a Pennsylvania accredited program the applicant must show a current license from the appropriate Pennsylvania licensing board. If the applicant is an out of Pennsylvania candidate the applicant must apply for a temporary educational license in Pennsylvania which may take 2 months to process. No resident can be in training at Geisinger Health System without a current Pennsylvania educational license. GHS staff will assist the applicant to obtain an educational license, but all costs are the responsibility of the applicant. Please contact Scott Jenkins at address below for assistance.

YOU SHOULD KNOW:

1) Visiting resident applications will not be accepted LESS THAN 30 DAYS before the MONTH SOUGHT FOR THE ROTATION and will be considered only after schedules have been completed for all affiliated residencies (approximately 60 days before rotation).

2) Visiting residents may be approved for a maximum of one sports medicine rotation at one of the two Geisinger campuses. Applicants are not assured to receive all weeks requested or for the first choice of location.

3) All documentation supporting your application must contain original signatures and institutional seal. Photocopies/faxes are acceptable if clear and verified as needed. The applicant is responsible for the clarity and legitimacy of all documents.

4) Geisinger does provide housing at certain locales on a first come basis. Housing is limited. Priority for rotations assignment is given for visiting residents who do not require housing.

5) Parking is free and meals are available at employee rates.

SECTION I: To be completed by applicant
APPLICATION OF resident FROM ACGME/AOA-ACCREDITED Residency
Dates Desired:
1st Choice _____ 2nd Choice _____ 3rd Choice _____
(Elective length 1 month)
Location: _____ Geisinger Wyoming Valley – Wilkes-Barre
_____ Geisinger Medical Center - Danville
1) Name _____
(Last) (First) (MI)
2) Present address: _____
_____
3) Daytime telephone _____ Alternate telephone _____
4) Medical school _____
5) Residency information:
Program Name: _____
Program Address: _____
_____
Program telephone: _____ Program Director: _____
6) Sports Medicine Experiences: (include dates): _____
_____
_____
7) Physical disability, if any: _____
9) Signature: _____ Date: _____

SECTION II: **To be completed by Residency Director of applicant's residency**
Please select the appropriate responses. This is to certify that the above named resident: has/ has not completed, or is expected to complete, all required core rotations of the first year of this program in a satisfactory professional manner.

S/he is/ is not in good standing at this institution.

S/he does/does not have our permission to take the above listed course for elective credit.

Malpractice insurance does/ does not cover the resident while away from our program. Personal health coverage under hospital policy does/ does not cover the resident while away from our campus.

Blood borne & airborne pathogens training has/ has not been taken during the current year for this resident.

Date:_____ Title_____
Printed Name: _____Signature_____
School Seal

10) Completed application should be sent to:

Geisinger Wyoming Valley Medical Center
Attn: Scott Jenkins
MC 37-70
1000 East Mountain Blvd.
Wilkes-Barre, PA 18711
Telephone: 570-808-7864
Fax: 570-808-5967

SECTION III: **To be completed by Sports Medicine Fellowship Director**
The application of the above-named resident is/is not approved for _____ (location) from_____ through _____. (S)He should report on _____ to_____(NAME AND PLACE).
Signature: _____ Date: _____

SECTION IV: To be completed by ACADEMIC AFFAIRS COORDINATOR FOR Sports Medicine Elective (Scott Jenkins)
This resident will /will not need housing for the following dates:
from_____ to _____.
Approved _____ signature

Health History Statement for visiting residents
NAME: _____
Last First MI
SS#: _____-____-_____
DOB:_____/_____/_____
Elective Dates (mo/yr):_____ to _____
Residency program _____
IMMUNIZATION DATE(S) GIVEN or TITER (*=REQUIRED)
Rubella
MMR
Varicella:
HepatitisB:
Dip/tet: Booster (most recent must be within 10 years)
Polio:

PPD: required for all residents except where there is a history of PREVIOUS POSITIVE PPD

_____ or _____
Date of last PPD Year of positive PPD
_____mm induration
CXR:
Required for residents with new or past positive
(>=10 mm, or >=5mm if immunocompromised)
PPD, regardless of BCG history.
DATE of CXR: ____/____/____
CXR Result:
_____
_____
_____
_____
_____/_____MD/DO/NP

Date:_____ Resident may document their own preventive health care as long as continuity physician identified who has medical record.
Print name of health care provider and telephone contact
number_____

Checklist:

A. Resident meets eligibility requirements: __
B. Permission for elective from Program Director (section II):__
C. Attached documentation of medical liability and health insurance; blood borne/airborne pathogens training; HIPPA and patient confidentiality (Eligibility requirements #3): __
D. Completed health history statement: ___
E. Brief personal statement with elective training goals: ___
F: Completed application (Section I): ___