Marshfield Clinic
Health System

Visiting Resident/Fellowship Application

All requested materials must be received in the Division of Education at least 60 business days (approximately 3 months) prior to the start of your requested experience or it may not be approved for processing.

Personal Information

Name (print) _____
First name Middle initial Last name

Are you a U.S. citizen: ☐ Yes ☐ No If no, visa status _____ Expiration date ____ /____ /____

Address _____

City _____ State _____ ZIP _____ Country _____

Home phone (_____) _____ Cell phone (_____) _____

Date of birth ____ /____ /____ E-mail address _____

Medical Degree

School _____

School address _____

City _____ State _____ ZIP _____ Country _____

Medical license state _____ Expiration date _____ /_____ /_____

Medical license state _____ Expiration date _____ /_____ /_____

Medical license state _____ Expiration date _____ /_____ /_____

Residency

Specialty & graduate level _____ Completion date ____ /____ /____

Hospital/Facility _____ Location _____

Residency Program contact _____ Phone (_____) _____

Email address _____

Fellowship

Specialty & graduate level _____ Completion date ____ /____ /____

Did you graduate from this program: ☐ Yes ☐ No

Hospital/Facility _____ Location _____

Fellowship Program contact _____ Phone (_____) _____

Email address _____

Marshfield Clinic follows CDC Immunization Guidelines of Health Care Workers

Marshfield Clinic Department Requesting Experience

Department requesting _____ Dates ____ /____ /____ to ____ /____ /____

Department requesting _____ Dates ____ /____ /____ to ____ /____ /____

International Medical Graduates Only

Are you certified by the E.C.F.M.G.: ☐ Yes ☐ No

If yes, certification number _____ Certification valid through date ____ /____ /____

Examinations taken: ☐ VQE Scores: 1. _____ 2. _____ 3. _____

☐ FMGEMS Scores: 1. _____ 2. _____

☐ NBME Scores: 1. _____ 2. _____ 3. _____

☐ USMILE Scores: 1. _____ 2. _____ 3. _____

Complete and Return

Return via email attachment the following information:

- Visiting Resident/Fellowship Application
- Letter of memorandum/contract/Program Letter of Agreement (PLA) from your institution (for an ongoing educational experience from your school/program)
- Documented proof of professional liability coverage during this experience
- Health Information Report
- Curriculum expectations of the learner and attending supervising the experience
- Background Information Disclosure
- Copy of Wisconsin medical license
  – Copy of a Resident Educational License (REL) if you do not have a Wisconsin medical license
- Copy of Residency/Fellowship Program Evaluation form
- Copy of Drug Enforcement Administration (DEA) certificate to include the number and expiration date
- Copy of National Provider Identifier (NPI) certificate to include the number and expiration date
- Copy of BLS certification (must be American Heart Association certification with hands-on [instructor-led] testing component)
- Copy of ACLS or PALS certification

Division of Education Contact Information

If you have any questions, email: residentprograms@marshfieldclinic.org

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