Charleston Area Medical Center
Office of Graduate Medical Education

Request for CAMC Rotation

The following information is needed to process all requests for visiting resident rotations at Charleston Area Medical Center. This information is required for Medicare cost reporting and documentation.

Date of request: _____ *(Note - Should be a min. of 90 days before start of rotation.)*

Resident's name: _____

___ Male ___ Female ___ D.O. ____ M.D. ____Other

Social security number: _____ Birth date: _____

NPI number: _____ Phone number: _____

Resident's address:

_____

Resident's email address: _____

Name of current institution/program: _____

Current program director: _____ Phone number: _____

Has your program director provided approval for this away rotation? _____ Yes _____ No, pending

Current PG level: _____ Program director's email address: _____

Medical school: _____ Graduation date: _____

CAMC rotation requested: _____

Rotation begin date: _____ Rotation end date: _____

Supervising CAMC physician: _____

Visiting Resident:

I certify that the information provided above is correct to the best of my knowledge:

Signature:_____ Date:_____