

**RESIDENT & FELLOW INFORMATION FORM**

For Use ONLY at Advocate Lutheran General Hospital

**Current Rotation** \_\_\_\_\_ **Start Date:** \_\_\_\_\_ **End Date:** \_\_\_\_\_

**RESIDENT & FELLOW BIOGRAPHICAL INFORMATION**

Last Name		First Name		Middle		<input type="checkbox"/> MD <input type="checkbox"/> PA <input type="checkbox"/> DO <input type="checkbox"/> DPM		Marital Status <input type="checkbox"/> Sgl <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid		
Spouse Name if married		Ethnic Origin		Visa Status <input type="checkbox"/> US <input type="checkbox"/> PR <input type="checkbox"/> J-1		Birth Date & Place		Gender <input type="checkbox"/> M <input type="checkbox"/> F		Computer Preferred Password

Languages spoken: \_\_\_\_\_

Current Street Address		City		State		ZIP Code		Social Security		Home Phone No. ( )	
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Permanent Address		City		State		ZIP Code		Primary E-mail			
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Secondary E-mail			Fax No. ( )		Pager No. ( )			Cellular No. ( )		
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**RESIDENCY/FELLOWSHIP EDUCATION AND TRAINING**

PGY-Year (Hired into)	Advocate Lutheran General Hospital rotating or new home program			Estimated Graduation Date		Scrub Size		Scrub Code	
						<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> L <input type="checkbox"/> XL <input type="checkbox"/> XXL		_____	

**IN CASE OF EMERGENCY**

Name of Local Friend or Relative	Relationship to Resident/Fellow	Home Phone No. ( )	Work Phone No. ( )	Cellular No. ( )	
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The following information **MUST** be attached to this form prior to you starting **ANY** rotation:

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|---|---|
| <input type="checkbox"/> Copy of Current CV                                 | <input type="checkbox"/> Current TB                       |
| <input type="checkbox"/> Copy of Medical License                            | <input type="checkbox"/> Letter of Good Standing          |
| <input type="checkbox"/> Copy of ECFMG certificate (Foreign Graduates Only) | <input type="checkbox"/> Signed Confidentiality Statement |
| <input type="checkbox"/> Proof of Malpractice coverage                      |   |

X \_\_\_\_\_  
 ALGH Program Approval signature for rotating resident/fellow \_\_\_\_\_ Date \_\_\_\_\_

**Fax your Resident/Fellow Information Form, Confidentiality Statement and Medical Information to the applicable department listed below.**

Department	Location	Coordinator	Fax (847)	Phone (847)	E-Mail Address
Anesthesiology	OR Suite	Patrick Fanning	723-3532	723-5524	<a href="mailto:Patrick.fanning@advocatehealth.com">Patrick.fanning@advocatehealth.com</a>
Emergency Med.	1 south	Jane Hynes	723-3532	723-7624	<a href="mailto:Jane.hynes@advocatehealth.com">Jane.hynes@advocatehealth.com</a>
Internal Medicine	6 South	Bea Socha	723-5615	723-1680	<a href="mailto:bea.socha@advocatehealth.com">bea.socha@advocatehealth.com</a>
Ob/Gyne	4 South	Anita Goodwin	723-1658	723-8031	<a href="mailto:anita.goodwin@advocatehealth.com">anita.goodwin@advocatehealth.com</a>
Pediatrics	2 South	Judy Fregetto	723.2325	723.5986	<a href="mailto:Judy.fregetto@advocatehealth.com">Judy.fregetto@advocatehealth.com</a>
Psychiatry	8 South	Roxana Geana	723.7312	723-5887	<a href="mailto:Roxana.Geana@advocatehealth.com">Roxana.Geana@advocatehealth.com</a>
Surgery	8 South	Eve Gorski	696.3394	723-5191	<a href="mailto:Eve.Gorski@advocatehealth.com">Eve.Gorski@advocatehealth.com</a>

