HARBOR-UCLA MEDICAL CENTER GME OFFICE
Affiliating Physician Questionnaire

Instructions: All sections of this form must be complete. Submit to the GME office at least two weeks prior to the start date of the rotation with Medical License, DEA, and ECFMG certificate (if applicable). Visiting Resident/Fellow registration procedure is available on the Harbor-UCLA website https://www.harbor-ucla.org/gme-resources/. All rotating physicians must register with the Graduate Medical Education by emailing this documentation to EVasquez@dhs.lacounty.gov. Questions may be referred via email.

Affiliate Physician's Full Name: _____ **Harbor E/C#** _____

Affiliate Hospital: _____ **Department:** _____

Affiliate Physician's Training Program/Specialty: _____

Physician's Home Address: _____
Street Address **City, State** **Zip Code**

Cell No.: _____ **Email:** _____ **Pager No.:** _____

Social Security #: _____ **DOB:** _____ **Postgraduate Year Level:** _____ **Fellow? Yes** ☐ **No** ☐
(PGY 1, 2, etc.)

Medical School: _____ **Month/Year Graduated:** _____

Physician's NPI #: _____ **MD** ☐ **DO** ☐ **DDS** ☐ Check here if not licensed ☐

Calif. Medical/PTL/Dental License #: _____ **Exp. Date:** _____ **Copy Required**

Physician DEA #: _____ **Exp. Date:** _____ **Copy Required**

NOTE: For International Medical Graduates, an ECFMG Certificate is required to begin rotations at Harbor-UCLA Medical Center. A copy of the ECFMG Certificate must be submitted to the GME Office with the completed Affiliating Physician Questionnaire.

International Medical Graduates: **ECFMG Certificate #:** _____ **Date Issued:** _____ **Copy Required**

Person to notify in case of emergency: _____ **Phone No.:** _____

Your Program Director's Name: _____ **Phone No.:** _____

NOTE: If a scheduling change occurs, i.e., change of date or cancellation, an adjusted form must be completed and turned in to the GME Office.

Harbor-UCLA Rotation Department/Service: _____

Harbor Service Rotation Dates: _____ to _____
Month/Day/Year **Month/Day/Year**

Harbor Program Coordinator: _____ **Phone No.:** _____

Signature: _____ **Date:** _____

FOR GME ADMINISTRATIVE USE ONLY

_____ **SYMPLR I.D.#**

_____ **SYMPLR Data Entry Date; Initials**

_____ **Confirmation Date (if different from above)**

☐	HR & GME LOG	☐	SCAN/FILE: S DRIVE/MEDHUB	☐	CONFIRM. EMAIL	☐	FINANCE EMAIL

REVISED 3/25