CLINICAL RESIDENT ROTATION APPLICATION

GENERAL INFORMATION (Please print clearly.)

First Name:_____ Middle Initial:_____ Last Name:_____

Home Address:_____ City:_____ State:_____ Zip:_____

Cell Phone:_____ Pager Number:_____

Circle One: MD / DO Circle One: UTMC / St. Vincent's Service:_____

DEA:_____ Exp. Date:_____ Oh License #:_____ Exp. Date: _____

Last 4 digits of SSN: _____ _____ _____ _____ (Needed for authentication of user) NPI: _____

Email Address:_____

I will be accessing the St. Luke's portal from:

Office/Practice Name:_____ Phone: _____

Office Address:_____ City:_____ State:_____ Zip:_____

Designated Office Point of Contact:_____

Return completed form to:
SLH Medical Staff Services
5901 Monclova Rd.
Maumee, OH 43537
Phone: 419-893-5917 · 419-891-8019
Fax: 419-891-8084
heather.vorraber@stlukeshospital.com
camille.thomas@stlukeshospital.com

Office Use Only:

Copy of form to:_____

Access Requested (Check all that apply):

_____iCare Physician Portal
_____iSite / PACS
_____SLH ChartMaxx
_____PICIS (Emergency Department Only)
_____Physician Census

RS#:_____ User Name:_____ Password:_____