Kaiser Permanente Southern California
Regional- Clinical Rotation Application

Name (please print)

Current Address: _____ (City) _____ (State) (Zip) _____

Permanent Address: _____ (City) _____ (State) (Zip) _____

Home Phone Number ( ) _____ Cell ( ) _____ ___

Pager ( ) _____ Email_____

Title: MS _____yr Resident _____yr Fellow/Affiliate _____yr

Specialty of Interest/Training _____

Have you been awarded a Kaiser Permanente scholarship? If so, please provide name of the award and year: _____

Have you completed a previous clinical rotation with Kaiser Permanente? No _____ Yes_____

If yes, please specify date, location, specialty, and mentoring physician:

_____

Rotation Specialty _____ Location/Medical Center _____

Dates Requested:

First Choice: _____ to _____ Second Choice: _____ to _____ Third Choice: _____ to _____

Core Curriculum _____ Elective_____

Medical School _____

Address (City) (State) (Zip)

Country _____ Month/Year Start Date: _____ Month/Year Anticipated/Graduation Date: _____

Institution

Address (City) (State) (Zip)

Country _____ Degree Received/Anticipated: _____

Month/Year Medical School Start Date: Month/Year Anticipated or Graduation Date:

Institution

Address (City) (State) (Zip)

Country _____ Degree Received/Anticipated: _____

Month/Year Medical School Start Date: Month/Year Anticipated or Graduation Date:

Specialty _____Institution_____

Address _____ (City) (State) (Zip) _____

Program Director: _____ Phone/E-mail: _____

Country _____ Month/Year Start Date _____ Month/Year Completion date: _____

PGY/Position: _____

Specialty _____ Institution_____

Address _____ (City) (State) (Zip) _____

Program Director: _____ Phone/E-mail: _____

Country _____ Month/Year Start Date _ Month/Year Completion date:

PGY/Position: _____

Please include any additional experiences on the last page of this form.

		Enclosed
Letter of Agreement and Good Standing from Dean of Student Affairs	Yes	No
Malpractice insurance statement	Yes	No
Official Medical School Transcript	Yes	No
Copy of License/Photo ID	Yes_____	No_____
Proof of Current Health Screening	Yes _____	No_____
Current BLS or ACLS	Yes _____	No_____
Current DEA & Medical License (if applicable)	Yes _____	No_____

Please list the scores for the examinations you have completed:

USMLE, Step I _____ USMLE, Step II _____ USMLE, Step III score _____

COMLEX, Part I _____ COMLEX, Part II _____ COMLEX, Part III _____

NBME, Part I score _____ NBME, Part II _____

Do any of these scores reflect multiple examination attempts? _____

If yes, please specify test and number of attempts. _____

Please complete all that are applicable:

Medical License # and State _____ Expiration Date_____

DEA #_____ Expiration Date _____

Do you have any of the following certifications?

___BLS ____ACLS _____PALS _____ Fluoroscopy

Rotation Application (Cont'd)

I attest that I am in good standing with my program and the information I have provided within this application is truthful and accurate to the best of my knowledge. I understand that any false or missing information may disqualify me from this position. I further declare that by submitting this application, I authorize the Kaiser Permanente and its representatives to contact persons associated with hospitals and institutions at which I have studied or trained and well as individuals whose names I have submitted in connection with this application. I hereby release from liability all representatives of the hospital and its professional staff for references performed in good faith in connection with evaluating my application and credentials; and release from liability all individuals and organizations that in good faith provide information to Kaiser Permanente, including otherwise privileged or confidential information.

Applicant Signature_____**Date:** _____