KAISER PERMANENTE SOUTHERN CALIFORNIA - ORANGE COUNTY MEDICAL AREA
STUDENT - CLINICAL ROTATION APPLICATION

Legal First Name:	Middle Name:	Legal Last Name:	Maiden/Other Name:

Current Address:	City, State, Zip:	Gender: ☐ **Male** ☐ **Female**
Permanente Address:	City, State, Zip:	

Email address:	Cell Phone:	Pager:

Which year of medical school will you be in during the time that you would like to rotate with us:

☐ **3rd Year** ☐ **4th Year** ☐ **Other** *(please specify)*

ROTATION DATES REQUESTED

Please list the medical student rotation that you are interested in
(If all three choices are not filled in – your approval process could be delayed)!!

Rotation:	Start Date:	End Date:
1.		
2.		
3.		

Which field of medicine do you see yourself entering following medical school? (IE. Residency)

MEDICAL SCHOOL INFORMATION

Medical School Name:

Address:	**City/State/Country**:
Start Date: *Month / Year*	**Anticipated Graduation Date:** *Month / Year*

PREVIOUS KAISER PERMANENTE EXPERIENCE

Have you completed a pervious clinical rotation at a Kaiser Permanente facility? ☐ **No** ☐ **Yes**

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

DOCUMENTS INCLUDED WITH THIS APPLICATION

REQUIRED PRE- APPROVAL DOCUMENTS MUST BE ATTACHED TO THIS APPLICATION – PLEASE CHECK

- ☐ Copy of **USMLE Scores (M.D. Candidates)**
- ☐ Copy of **COMLEX and USMLE Scores (D.O. Candidates)**
- ☐ Brief Personal Statement

Your personal statement should address the following questions (Be specific)

- **Why do you want to rotate with Kaiser Orange County?**
- **Why do you want to rotate in the department of choice?**
- **What are your future plans in medicine?**

EXAMINATIONS/LICENSURE/CERTIFICATIONS

Please list the scores for the examinations you have completed:

USMLE, Step I	______	USMLE, Step II	______	USMLE, Step III	______
COMLEX, Part I	______	COMLEX, Part II	______	COMLEX, Part III	______

Do any of these scores reflect multiple examination attempts? ______ **PLEASE NOTE: FAILED FIRST ATTEMPTS ARE NOT ACCEPTED FOR FAMILY MEDICINE ROTATIONS WITHOUT SIGNIFICANT IMPROVEMENT ON SUCCESSFUL SECOND ATTEMPT.**

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

Please complete all that are applicable:

Certification	Number	Expiration Date	Certification	Expiration Date
☐ Medical License # and State	______	______	☐ BLS	______
☐ DEA #	______	______	☐ ACLS	______
☐ Fluoroscopy	______	______	☐ PALS	______

APPLICATION ATTESTATION

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:** ______________

ATTN: APPLICATION FOR ROTATIONS IN ORANGE COUNTY MAY BE ACCEPTED FROM STUDENTS CURRENTLY ENROLLED IN A U.S. ACCREDITED MEDICAL SCHOOL PROGRAM ONLY; INTERNATIONAL STUDENTS MAY APPLY THROUGH http://www.medstudent.ucla.edu/visitingstudents **FOR INFORMATION**