Kaiser Permanente Southern California

Student - Clinical Rotation Application for Family MED, Geriatrics and Sports MED

Name (please print) _____

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

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

Home Phone Number ( ) _____ Cell ( ) _____

Pager ( ) _____ Email_____

Title: Student _____yr

Specialty of Interest/Training _____

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

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

_____

ROTATION DATES REQUESTED

Rotation Specialty _____ Location/Medical Center _____

Dates Requested >>>: **(If all three choices are not filled in – this could delay your approval process)!!**

First Choice: _____ to _____ 2nd Choice: _____ to _____ 3rd Choice: _____ to _____

MEDICAL EDUCATION

Medical School _____

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

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

DOCUMENTS INCLUDED WITH THIS APPLICATION

ATTACHED PRE- APPROVAL DOCUMENTS TO THIS APPLICATION - **Please √ off each document to ensure all documents have been attached.**

- Un-official Medical School Transcript Yes _____ No _____
- Copy of **USMLE** or **COMLEX SCORES** Yes_____ No_____
- Personal Statement Yes_____ No_____

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

- **Why do you want to rotate with Kaiser Fontana?**
- **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 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

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:** _____

NOTE: YOUR EVALUATION WILL NOT BE ISSUED UNTIL YOUR KAISER ON-LINE COMPLIANCE TRAINING HAS BEEN COMPLETED!!

ATTN: AMERICAN UNIVERSITY OF THE CARIBBEAN (AUC) STUDENTS MUST HAVE COMPLETED ALL CORE ROTATIONS AT KERN COUNTY, FM PREFERS A EVALUATION FROM A PREVIOUS ROTATION AND YOU MUST HAVE A MINIMUM SCORE STEP 1 OF 90.