

**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.**