Kaiser Permanente Southern California – Clinical Rotation Application 24-25

SBC – Fontana (MS3 applicants only)

Name (please print) _____

Current Address: _____ _____ _____ _____
STREET CITY STATE ZIP

Permanent Address: _____ _____ _____ _____
STREET CITY STATE ZIP

Phone Numbers: Cell: _____ Home: _____

Email: _____

Title: Medical Student -_____ yr. Specialty of Interest/Training _____

Have you been awarded a Kaiser Permanente scholarship? ☐Yes ☐No If so, please provide name of the award and year:

_____

Have you completed a previous clinical rotation with Kaiser Permanente? ☐Yes ☐ No If yes, please specify date, location, specialty, name of mentor:

_____

ROTATION DATES REQUESTED

Internal Medicine Primary Care Clinic

Block 2 7/29/24-8/25/24	**Block 3 8/26/24-9/22/24**	**Block 4 9/23/24-10/20/24**	**Block 5 10/21/24-11/17/24**
Block 6 11/18/24-12/15/24	**Block 7 12/16/24-1/12/25**	**Block 8 1/13/25-2/9/25**	**Block 9 2/10/25-3/9/25**
Block 10 3/10/25-4/6/25	**Block 11 4/7/25-5/4/25**	**Block 12 5/5/25-6/1/25**	**Block 13 6/2/25-6/29/25**

Family Medicine Primary Care Clinic

Block 2 Closed	**Block 3 8/26/24-9/22/24**	**Block 4 9/23/24-10/20/24**	**Block 5 10/21/24-11/17/24**
Block 6 11/18/24-12/15/24	**Block 7 12/16/24-1/12/25**	**Block 8 1/13/25-2/9/25**	**Block 9 2/10/25-3/9/25**
Block 10 3/10/25-4/6/25	**Block 11 4/7/25-5/4/25**	**Block 12 5/5/25-6/1/25**	**Block 13 Closed**

YOU MUST INDICATE A MINIMUM OF 3 CHOICES, NOT NECESSARILY IN THE SAME SPECIALTY. FAILURE TO DO SO MAY DELAY PROCESSING!

Rotation Specialty _____ 1st Choice: _____ to _____

Rotation Specialty _____ 2nd Choice: _____ to _____

Rotation Specialty _____ 3rd Choice: _____ to _____

Rotation Specialty _____ 4th Choice: _____ to _____

Rotation Specialty _____ 5th Choice: _____ to _____

Rotation Specialty _____ 6th Choice: _____ to _____

Rotation Specialty _____ 7th Choice: _____ to _____

Rotation Specialty _____ 8th Choice: _____ to _____

Rotation Specialty _____ 9th Choice: _____ to _____

Rotation Specialty _____ 10th Choice: _____ to _____

MEDICAL EDUCATION

Medical School _____

Address _____
STREET CITY STATE ZIP

Country _____ Start Date: _____ Graduation Date (or expected):_____

Contact: _____ Email:_____

PRE-APPROVAL DOCUMENTS INCLUDED WITH THIS APPLICATION

	Enclosed?
Letter of Agreement and Good Standing from Dean of Student Affairs	☐Yes ☐No
Official Medical School Transcript	☐Yes ☐No
Copy of USMLE or COMLEX Transcript	☐Yes ☐No
Personal Statement/Letter of Intent	☐Yes ☐No
Curriculum Vitae	☐Yes ☐No
Copy of License/Photo ID	☐Yes ☐No

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 _____ Step II _____ Step III _____

COMLEX: Part I _____ Part II _____ Part III _____

NBME, Part I score _____ NBME, Part II _____

Do any of these scores reflect multiple examination attempts? ☐Yes ☐No

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

Please complete all, as applicable:

Medical License # and State _____ Exp. Date _____ DEA#_____ Exp. Date _____

Do you have any of the following certifications? ☐BLS Exp. Date _____ ☐ ACLS Exp. Date _____

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:** _____