

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				Family Medicine Primary Care Clinic			
Block 2 7/27/26 - 8/23/26	Block 3 8/24/26 - 9/20/26	Block 4 9/21/26 - 10/18/26	Block 5 10/19/26 - 11/15/26	Block 2 8/10/26 - 8/23/26	Block 3 8/24/26 - 9/20/26	Block 4 9/21/26 - 10/18/26	Block 5 10/19/26 - 11/15/26
Block 6 11/16/26 - 12/13/26	Block 7 12/14/26 - 1/10/27	Block 8 1/11/27 - 2/7/27	Block 9 2/8/27 - 3/7/27	Block 6 11/16/26 - 12/13/26	Block 7 12/14/26 - 1/10/27	Block 8 1/11/27 - 2/7/27	Block 9 2/8/27 - 3/7/27
Block 10 3/8/27 - 4/4/27	Block 11 4/5/27 - 5/2/27	Block 12 5/3/27 - 5/30/27	Block 13 5/31/27 - 6/27/27	Block 10 3/8/27 - 4/4/27	Block 11 4/5/27 - 5/2/27	Block 12 5/3/27 - 5/30/27	Block 13 Closed

***FM Applicants may request own dates**

YOU MUST INDICATE A MINIMUM OF 3 CHOICES IN ORDER OF PREFERENCE. THEY DO NOT NECESSARILY NEED TO BE IN THE SAME SPECIALTY. FAILURE TO DO SO MAY DELAY PROCESSING!

1. Rotation Specialty: _____ From: _____ To: _____
2. Rotation Specialty: _____ From: _____ To: _____
3. Rotation Specialty: _____ From: _____ To: _____
4. Rotation Specialty: _____ From: _____ To: _____
5. Rotation Specialty: _____ From: _____ To: _____
6. Rotation Specialty: _____ From: _____ To: _____
7. Rotation Specialty: _____ From: _____ To: _____

