Deaconess Health System

MEDICAL STUDENT ELECTIVE APPLICATION

Name: _____DOB: _____

Mailing Address: _____

City: _____ State/Zip Code: _____

Email Address (required): _____ Phone: _____

Emergency Contact Name/ Phone: _____

Medical School/ Year of Study: _____

Medical School contact name: _____ E-Mail: _____

Matriculation Date: _____ Expected Graduation Date: _____

USMLE/ COMLEX 1 Pass/Fail: _____ Attempts: _____

USMLE/COMLEX 2 Pass/Fail: _____ Attempts: _____

Rotation/Specialty requested: _____Requested date: _____

Geographic area you plan to practice medicine: _____

Areas of medical interest: _____

U.S. citizen or permanent resident: _____

Have you ever elected, or been asked/directed to leave any educational program and/or training prior to completion?

Yes_____ No _____

Have you ever been suspended from an educational program and/or training?

Yes_____ No_____

Have you ever pled guilty to or been convicted of a crime or offense other than a minor traffic violation?

Yes_____ No_____

Students wishing to perform clinical rotations of hospital activities must submit the following information to student.rotations@deaconess.com:

1. **Elective Medical Student Application**
2. **Letter of Introduction outlining your interest in an elective at Deaconess**

I understand that I cannot start any rotation at Deaconess until all paperwork is submitted, completed and approved by Deaconess.

Student signature: _____ **Date**: _____