ROTATION APPLICATION

Name:
Last First MI

Medical School: MS Year:

*Last 4 digits of SSN#: *Birth Date:
***(Note: this information is required for Computer Patient Information access purposes only as a unique identifier)**

ROTATION REQUESTED

Specialty: Rotation Dates:

If this rotation is not available during the dates given, please indicate an alternate rotation or dates.

Alternate: Rotation Dates:

Primary reason for applying to Mount Carmel for this rotation:

Fulfill a requirement

I have an interest in this specialty for residency training

I am considering applying to Mount Carmel for residency training

Recommended by: another student a faculty member other person

Present Address Permanent Address (if different)

Phone: Phone:

Email:

Please send correspondence to my present address permanent address.

Upon receipt of this application and written verification from your medical school of professional liability insurance and good standing, we will process your request. If we are able to accommodate your primary or alternate request, we'll send you a confirmation and information packet within 4 weeks. If we cannot accommodate your request, we will notify you by email immediately.

Be sure to have the appropriate school official complete the second page of this application.

Student signature Date

For more information: https://www.mountcarmelhealth.com/mount-carmel-gme/residents/students/info

The *Medical Student* should email completed application packet including any additional documentation required to: GMErotations@mchs.com

ROTATION APPLICATION (PAGE 2)

To be completed by Clinical Clerkship Director or appropriate college official.

This student (Name: ____________________________________) is in good standing and has approval to schedule the rotation or alternate rotation listed on the reverse side of this application.

Signature of authorized official | Date

Printed name of authorized official | Telephone Number

Title | Email Address

For more information: https://www.mountcarmelhealth.com/mount-carmel-gme/residents/students/info

The *Clinical Clerkship Director/Appropriate College Official* should either email or mail this form and any additional documents indicated as required to Mount Carmel Medical Education.

You may return this form to: Scan/email: GMErotations@mchs.com

or mail:
Mount Carmel Medical Education;
5300 North Meadows Drive,
Building 2, Suite 5900
Columbus, Ohio 43222