MEDICAL EDUCATION
16001 West Nine Mile Road
Southfield, Michigan 48075

APPLICATION FOR SENIOR ELECTIVE

Email Address ______________________________

NAME ____
(Last) (First) (Middle)

Social Security No. ______________________________

Rotations Requested: 1. ________________________________ Dates Requested: From __________ to __________

2. ________________________________ Dates Requested: From __________ to __________

3. ________________________________ Dates Requested: From __________ to __________

4. ________________________________ Dates Requested: From __________ to __________

5. ________________________________ Dates Requested: From __________ to __________

Present Address

____
(Street) (City) (State) (Zip Code)

Present Phone Numbers: Day ( ) ______________________ Evening ( ) ______________________

Permanent Address: (Name of person through whom I can always be contacted.)

C/O ____
(Street) (City) (State) (Zip Code)

Permanent
Phone No. ( ) ______________________

MEDICAL EDUCATION

Medical School Presently Enrolled in ____
(Name) (City) (State)

UNDERGRADUATE AND/OR GRADUATE EDUCATION

College(s) (Month/Year) Dates Attended Major Degree (if any)

____
Name From To

____
City State

____
Name_ From To

____
City State

______________________________________ ______________________________
(Signature) (Date)

NOTE: The signature and date on this statement must be original.

All senior elective rotations must be approved by the medical school and Providence Hospital Department of Medical Education.

Prior to rotation, students must show evidence of recent Rubella Titer or proof of vaccination; a recent T.B. Skin Test, or a Chest x-ray within 6 months.

International Medical Students are requested to submit with this application, medical school transcripts, evidence of malpractice insurance, scores on Part 1 of the USMLE, and a short resume.