APPLICATION FOR FAMILY MEDICINE ROTATION

THANK YOU FOR YOUR INTEREST IN THE HONORHEALTH-SCOTTSDALE OSBORN MEDICAL CENTER FAMILY MEDICINE RESIDENCY PROGRAM

YOUR APPLICATION WILL BE REVIEWED AND NOTIFICATION MADE BEGINNING IN APRIL OF EACH YEAR.

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Phone (480) 882-4890
Fax (480)882-6801

NAME: ____

MAILING ADDRESS: ______________________________________

Home TEL: ______________ CELL: ________________ E-MAIL: __________________

ARE YOU A U.S. CITIZEN or PERMANENT RESIDENT? (We do not sponsor Visas): ____________

IN CASE OF EMERGENCY, PERSON(S) TO NOTIFY:

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REQUESTED START & ENDING DAY OF CLERKSHIP:

	INPATIENT	OUTPATIENT
1ST CHOICE: ____________________	☐	☐
2nd CHOICE: ____________________	☐	☐
3rd CHOICE: ____________________	☐	☐

EDUCATION:

COLLEGE: ______________________________________

MEDICAL SCHOOL: ______________________________________

ANTICIPATED GRADUATION DATE FROM MEDICAL SCHOOL: ______________

GRADUATE SCHOOL: ______________________________________

OTHER FORMAL EDUCATION: ______________________________________

HAVE YOU EVER HAD TO REPEAT OR REMEDIATE ANY COURSE OR ROTATION? __________

IF YES, PLEASE EXPLAIN: ______________________________________

HAVE YOU EVER HAD TO REPEAT A BOARD EXAM? ______________________________________

IF YES, PLEASE EXPLAIN: ____

BOARD SCORE - PART I: _________________________

BOARD SCORE – PART II (if available):__________________

PLEASE PROVIDE A TRANSCRIPT OF CLASSES AND GRADES TO DATE WITH YOUR APPLICATION.

PLEASE STATE YOUR REASON FOR REQUESTING A CLERKSHIP IN FAMILY MEDICINE AND WHY YOU CHOSE OUR PROGRAM:

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FUTURE GOALS IN MEDICINE:

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IF YOUR APPLICATION IS APPROVED, YOU WILL NEED TO PROVIDE THE FOLLOWING:

1. A LETTER FROM THE DEAN'S OFFICE OF YOUR MEDICAL SCHOOL, VERIFYING YOUR STANDING AND MALPRACTICE COVERAGE.
2. A COPY OF YOUR BOARD SCORES, PART I and PART II (if available).
3. THE MOST CURRENT TRANSCRIPT OF CLASSES AND GRADES.
4. A CURRENT IMMUNIZATION RECORD AND PROOF OF HEALTH INSURANCE.
5. THE NAME, ADDRESS AND TITLE OF THE APPROPRIATE PERSON WITHIN YOUR MEDICAL SCHOOL WHO WILL SIGN AN AFFILIATION AGREEMENT IF ONE IS NEEDED.
6. YOUR SCHOOL'S CURRENT EVALUATION FORM.

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