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| **Medical Student Application** | | | |
| **First Name:** |  | **Last Name:** |  |
| **Email Address:** |  | **Phone Number:** |  |
| **Address:** |  | **City/State/Zip:** |  |
| **Medical School Name:** |  | **Medical School Location (city and**  **state, or country):** |  |
| **Expected Med School Graduation Date:** |  | **Current Medical School Year:** |  |
| **Briefly explain why you would like to rotate with our residency program:** | | | |
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| **2-week and 4-week externship programs run year-round. Please indicate your preferred externship start dates, 2-week or 4-week program participation:** | | | |
| **1st Choice** | | | |
| **Preferred Start Date:** |  | **Program Length ( 2 or 4 weeks):** |  |
| **2nd Choice** | | | |
| **Preferred Start Date:** |  | **Program Length ( 2 or 4 weeks):** |  |
| **3rd Choice** | | | |
| **Preferred Start Date:** |  | **Program Length ( 2 or 4 weeks):** |  |
| **Do you have any special needs we should know about?** | | | |
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| **Will you be requesting any time off during the Externship? If so, please explain.** |
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| **Did you pass COMLEX Level 1 or USMLE Step 1 on the first attempt?** |
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| **Are there any gaps or remediation's in your education? If yes please explain.** |
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| **How did you hear about us?** |
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**Please Read the Following Terms Carefully. Select Each Checkbox If You Agree:**

I hereby certify that all the information listed on this form is true and complete. I understand that any false, incomplete or misleading information given by me on this application is sufficient cause for rejection.

I also understand and agree that any false, incomplete or misleading information discovered on this application at any time after I begin the Externship Program may result in my dismissal

