



**APPLICATION FOR SENIOR ELECTIVE**

Email Address \_\_\_\_\_

NAME \_\_\_\_\_  
(Last) (First) (Middle)

- 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 \_\_\_\_\_  
 6. \_\_\_\_\_ Dates Requested: From \_\_\_\_\_ to \_\_\_\_\_

Address \_\_\_\_\_  
(Street) (City) (State) (Zip Code)

Phone Numbers: Home ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

**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		

\_\_\_\_\_  
(Name or Signature) (Date)

**NOTE:**

The medical school and St. John Hospital Department of Medical Education must approve all senior elective rotations.  
 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.