Graduate Medical Education- Medical/PA Student Extramural Rotation Application

Original Returned to:
Orlando Health
Graduate Medical Education Administration
86 W. Underwood Street, Suite 100
Orlando, Fl 32806
(321) 841-5243

Please submit completed applications to gme.administration@orlandohealth.com or fax to 321-843-1791 all incomplete applications will not be processed until complete.

Part I To be completed in full by Applicant – "please print or type"

Student's Name _____ Phone # _____
Last First Middle Initial

Address _____
(Street Number/Name) (City) (State) (Zip)

E-Mail Address: _____ In which area of medicine are you applying for residency _____

Social Security # _____-_____-_____ D/O/B _____ Sex M ____ F ____

Year in Medical School _____ Name of Medical School _____
(at the time of rotation)

Rotation Requested: _____ (use a separate application for each rotation)

Dates Requested: From _____ thru _____ OR From _____ thru _____

Application/Processing Fee of $50.00 per rotation -**ONLY SUBMIT** if you receive an approval letter for the rotation
Approved students will receive a meal card with a designated amount per rotation; access to free wifi on campus, 24 hour access to on-campus library, and free parking while on rotation.

Is Housing needed? Yes _____ No _____ *(Housing is based upon availability at the time of application approval. Effective 10/08/2015 A fee of $400.00 fee per 4-week rotation applies to students from schools that do not have a master affiliation agreement with Orlando Health.)*

Signature of Student _____ Date _____

Part II To be completed in full by Dean or comparable official of the medical school where student is enrolled

The following must be submitted with this application for the review process:

1. Curriculum Vitae (CV), Transcripts, USMLE Step 1 or COMLEX Step 1 scores
2. Copy of proof of medical malpractice insurance stating coverage limits and time period (current certificate of insurance).
3. Copy of proof of personal health insurance (i.e. current insurance card).
4. Evaluation Form.

Please acknowledge the following: This student is approved to take this course ____ **for credit** ____ **not for credit**. At the conclusion of the course an evaluation report ____ **will** ____**will not** be required. If the evaluation is required, please attach to the application. DO NOT SEND WITH THE STUDENT. A criminal background check ____**has** ____**has not** been completed on the student by a law enforcement agency. Current immunization records **are** ____ **are not** _____ on file with the medical school.

School _____ Signature _____

Address _____ Printed Name _____

City _____ State _____ Zip _____ Phone _____ Date _____

Student Coordinator Name _____ E-Mail address _____

Part III To be completed by Orlando Health

Request is: Not Approved ☐ Approved ☐ Rotation Dates: From _____ thru _____

Signature _____/Program Director/Academic Chair Date_____

Signature _____/Director of Graduate Medical Education Date_____

"Applicant will be notified by e-mail of approval/non-approval - a copy of the approved letter will be sent to the school"