



When it matters most.

GRADUATE MEDICAL EDUCATION

Medical Student Extramural Rotation Application

Original Returned to: Orlando Health
Graduate Medical Education Administration
86 W. Underwood Street, Suite 100
Orlando, FL 32806-2093
(321) 841-5243

Originals Only - Incomplete Applications
Will Be Returned

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

Student's Name Last First Middle Initial Phone #

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

Is Housing needed? Yes No (Housing is based upon availability at the time of application approval. A \$325.00 fee per 4-week rotation applies for out-of-state students.)

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. Copy of proof of medical malpractice insurance stating coverage limits and time period (current certificate of insurance).
2. Copy of proof of personal health insurance (i.e. current insurance card).
3. Evaluation Form.
4. Transcripts.

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

Part III To be completed by Orlando Health

Request is: Not Approved Approved Rotation Dates: From thru

Signature /Academic Chair Date

Signature /Chief Academic Medical Officer Date

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