ORLANDO HEALTH®

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
(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.

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"