

Medical Student ROTATION APPLICATION



Name:

Last

First

Undergraduate:

MS Year:

Medical School:

Birth Date:

Grad Date:

ROTATION REQUESTED

Specialty:

Rotation Dates:

If this rotation is not available during the dates given, please indicate an alternate rotation or dates.

Alternate:

Rotation Dates:

Primary reason for applying to Johns Hopkins All Children's Hospital for this rotation:

Fulfill a requirement

I have an interest in this specialty for residency training

I am considering applying to Johns Hopkins All Children's for residency training

Present Address

Phone:

Email:

Approval of Student's Medical School

1. Is the medical student in good standing at this institution?
2. Does malpractice insurance cover the student while away from their school?
3. Is personal health coverage in effect while the student is at Johns Hopkins All Children's Hospital?
4. Is the medical student approved to take this elective for credit?
5. Has the student completed training on universal precautions for the handling of body fluids and sharp instruments?
6. Does your medical school require a criminal background check?

Medical School Official's Signature: _____

Please email application, CV and medical school transcripts to Chelse Crump: ccrump6@jhmi.edu