Jefferson Health
HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

Jefferson Health – Northeast
Visiting Medical Student Application

Today's Date: _____

Name: _____
First Middle Initial Last

Email Address: _____Phone Number: _____

Rotation Program Requested:_____

Requested Rotation Start Date: _____ Rotation End Date: _____

Alternate Rotation Dates: _____

IF THIS IS AN AUDITION ROTATION, PLEASE LET US KNOW SO THAT WE CAN PLAN YOUR ROTATION ACCORDINGLY.

What do you hope to accomplish at this rotation? _____

_____

Medical School: _____ Year of Graduation: _____/____
Month/Year

Administrative Contact: _____ Phone Number:_____

COMLEX 1 Score: _____ USMLE Score 1: _____

COMLEX 2 Score: _____ USMLE Score 2: _____

Do you plan to apply for a Jefferson Health – Northeast residency? If interested, please indicate below.

- ☐ **Emergency Medicine**
- ☐ **Family Medicine**
- ☐ **Internal Medicine**
- ☐ **Not interested in an Aria residency**
- ☐ **Internal Medicine/Emergency Medicine**
- ☐ **Family Medicine/Emergency Medicine**

Additional Information: _____

_____

_____

Email completed application to: doris.mcneill@jefferson.edu

***No other documents are required until your application is approved**
For more information call 215-612-4609