

Miami Children's Hospital
Application for Core/Sub-I/Elective Rotation
For Students of
Approved Medical/Dental Schools and Programs

Name (Last Name, First, M.I.): _____

Social Security #: _____ Date of Birth: _____

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____

Daytime Telephone Number: _____ Evening: _____

E-mail Address: _____

In case of an emergency:

Name of nearest relative: _____

Relationship: _____ Telephone Number: _____

Graduate/Post Graduate Education:

Complete Name of Medical School/Training Program: _____

Address: _____ City: _____

State: _____ Zip: _____

Name of Dean/Program Director: _____ Graduation Date: _____

Credentials which must accompany application:

- 1) Curriculum Vitae (CV)
- 2) Medical Records including Immunization Record
- 3) Letter from Dean of Medical School or Residency Director stating good standing
- 4) Medical School Transcripts
- 5) School's Evaluation Form
- 6) Passport Size Photo
- 7) Copy of current Malpractice Insurance Coverage in the amount of \$1million/\$3 million

Rotation in the department of: _____ **From:** _____ **To:** _____

1) _____

2) _____

3) _____

(Minimum of 4 weeks per rotation)

I have previously applied for an Elective at MCH. Yes _____ NO _____

Proof of Immunization:

We require that all students who rotate through our facility provide with this application a copy of the results of the screening or immunizations which your institution does for the following: Tuberculosis, Hepatitis B, Measles, Rubella, and Varicella.

Signature: _____ Date: _____