



FOURTH YEAR MEDICAL STUDENT ROTATION

Thank you for your recent inquiry concerning a fourth year rotation at Scripps Mercy Hospital Chula Vista for the upcoming academic year. Enclosed, is an application form for visiting students. **Please note** that we do not provide a stipend nor furnish room and board.

Eligibility:

- 1) Student must currently be enrolled in a LCME approved medical school in the United States or Canada and have completed their core clerkship training.
- 2) Students must have a good academic standing with their medical school and receive academic credit from their school for the elective taken at Scripps Mercy Hospital Chula Vista.
- 3) Students **are required** to provide proof of health insurance coverage.
- 4) Students must also provide proof of negative TB skin test or negative chest x-ray report taken within the 12 months prior to the actual elective dates. Additionally, proof of immunity to rubeola, mumps and rubella is a requirement. It is suggested that you be vaccinated against Hepatitis B and have immunity to polio and tetanus, although this is not mandatory.

Before your application can be acted upon, we must receive the following:

- 1) Application form with Section I completed by the student and Section II completed by the Dean or school official with the school seal imprinted.
- 2) Completed Verification of Immunizations and Health Insurance form signed by physician or school official.
- 3) A letter of recommendation from a senior faculty member of the same department (Family Medicine) at your medical school.
- 4) A brief statement explaining why you wish to complete a medical student rotation at Scripps Mercy Hospital Chula Vista and your plans for residency.

If you have any questions, please feel free to contact us.

Sincerely yours,

A handwritten signature in blue ink, appearing to read "M. McKennett".

Marianne McKennett, M.D.
Program Director



APPLICATION FOR ROTATION

Complete Sections I and II and return to: Scripps Mercy Hospital Chula Vista, Department of Medical Education, 499 H Street, Chula Vista, CA 91910. Attach completed immunization form and appropriate letter of recommendation.

SECTION I. To be completed by student. Please type or print legibly.

Name: _____ Phone: _____ Pager: _____

Mailing Address: _____

E-mail Address: _____

I am registered _____ Year medical student at _____ medical school. I [will / will not] apply for family medicine residency position at Scripps Mercy Hospital Chula Vista.

Premedical Education: College or University _____ Degree _____

Date of Graduation _____ Other degrees or advanced education _____

Honors or Awards _____

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**SECTION II.** To be completed by Dean of Students or designated official at student’s school.

The above named student is in good standing at this institution and [will OR will not] pay tuition at this school during the period indicated. ***Medical malpractice insurance and personal health insurance ARE in effect while student is away from their school.*** The student is authorized to take this clinical instruction and will receive academic credit for the experience. **IF AN EVALUATION IS REQUIRED, PLEASE ATTACH THE FORM.**

School Address: \_\_\_\_\_  
\_\_\_\_\_

SCHOOL  
SEAL

Phone: \_\_\_\_\_

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**SECTION III.** To be completed by Scripps Mercy Hospital Chula Vista designated official:

You are enrolled in the Family Medicine Rotation for Medical Students for the period of \_\_\_\_\_. This is a commitment which you are expected to honor. If you find you are unable to meet this commitment, you are responsible for notifying us within 30 days so that another student may have this opportunity.

**THIS SIGNITURE IS REQUIRED  
FOR OFFICIAL ENROLLMENT**

\_\_\_\_\_  
Residency Coordinator

\_\_\_\_\_  
Date

Report to Medical Education, at 499 H Street, Chula Vista, CA 91910 at 8:30 a.m. on your first day. Please wear your school name badge and white coat. If you have any questions, please call (619) 691-7587.



**SCRIPPS MERCY HOSPITAL CHULA VISTA  
VERIFICATION OF IMMUNIZATIONS AND HEALTH INSURANCE**

Name: \_\_\_\_\_

Medical School: \_\_\_\_\_

|                                                                                                                                                       | <b>Date of First Dose</b> | <b>Date of Second Dose (measles and chicken pox only)</b> | <b>Date of illness or serologic titer</b> |
|-------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-----------------------------------------------------------|-------------------------------------------|
| <u>MEASLES (Rubeola)</u><br>2 doses live attenuated vaccine since 1968 <u>or</u> proof of immunity (documented illness or positive serology).         |                           |                                                           |                                           |
| <u>MUMPS:</u><br>1 dose live attenuated vaccine <u>or</u> proof of immunity (documented illness or positive serology).                                |                           |                                                           |                                           |
| <u>GERMAN MEASLES (Rubella)</u><br>1 dose live attenuated vaccine or proof of immunity (documented illness <u>or</u> positive serology).              |                           |                                                           |                                           |
| <u>VARICELLA (Chicken pox)</u><br>2 dose of live attenuated vaccine since 1995 <u>or</u> proof of immunity (documented illness or positive serology). |                           |                                                           |                                           |

A tuberculin skin test must be taken within one year prior to the rotation.

Date: \_\_\_\_\_ Test: \_\_\_\_\_ Result: \_\_\_\_\_

Students testing positive must provide negative chest x-ray report taken within one year to the student's rotation at Scripps Mercy Hospital Chula Vista. Exception: Students given INH therapy – please provide documentation.

**Note: Although all students are urged to undergo vaccination against Hepatitis B prior to beginning clinical duties, PROOF IS NOT REQUIRED.**

\_\_\_\_\_  
Signature of Physician or School Official

\_\_\_\_\_  
Date

\*Also required is evidence of health insurance. Please attach a copy of such proof.