SCRIPPS MERCY HOSPITAL - APPLICATION FOR SUBINTERNSHIP

Complete Sections I and II and return to: Scripps Mercy Hospital, Department of Medical Education, 4077 Fifth Ave., Mer 35, San Diego, CA 92103-2180. Attach completed immunization form, personal statements and appropriate letter of recommendation.

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

NAME First: ______________ Mi: ____ Last: __________________ PHONE: __________________ PAGER: ________________

MAILING ADDRESS ______________________________________ SS# _____________________

______________________________________ DOB: _____________________

E-MAIL ADDRESS ______________________________________ EXPECTED GRADUATION DATE: __________________

I am a registered _____ Year medical student at _________________________________ medical school. I [will / will not] apply for a residency position at Scripps Mercy Hospital in ☐ Internal Medicine or ☐ Transitional Year.
I am applying for a subinternship in: Inpatient Internal Medicine*
**Other electives are not formally offered through the Department of Medical Education, but we must still have an application and supporting data on file.*

******See attached available rotation dates to choose from:**

First Choice: From ____________ To ___________ **Second Choice:** From ____________ To ______________

Premedical Education: College or University ___________________________ Degree: ____________
Date of Graduation ___________ Other Degrees or Advanced Education ____
Honors or Awards ____

Signature _________________________________ Date ________________

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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 the 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 FORM AND RETURN WITH APPLICATION.

The student will have completed the following required clerkships prior to this elective.

Core Course	# weeks completed	Date completed
Medicine	________	________
Surgery	________	________
Ob/Gyn	________	________
Pediatrics	________	________
Psychiatry	________	________
Other	________	________

SCHOOL OFFICIAL:

Signature:

Date: ________________________________

Name: ________________________________
Title:

SCHOOL SEAL

USMLE Step 1 (to be eligible for subinternship, must have taken and passed): Date Taken: ___________ Score: ____________

School Address: ____
____ Phone: ___________________________

****Once your application has been reviewed by the committee, you will be contacted via email and provided with a letter confirming your rotation. A confirmation letter will also be sent to your school.

SCRIPPS MERCY HOSPITAL

VERIFICATION OF IMMUNIZATIONS AND HEALTH INSURANCE

Name:

Medical School:

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

Hepatitis B: 3 doses of vaccine and/or proof of immunity.	**Date of First Dose:**	**Date of Second Dose:**	**Date of Third Dose:**	**Date of Titer:**

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

Date_____ Test_____ Result
Positive reactors must provide proof of no symptoms of TB. Exception: Students given INH therapy - please provide documentation.

Have you ever been fit tested for a TB respirator?

☐ Yes Date tested, brand and size: _____ ☐ No

Note: If we have your brand and size respirator in stock, we will provide you with a mask for your rotation. If not, or if you have not been tested, we will have you fit tested at check-in.

Dates of TDAP Vaccination: _____ & Current Influenza Vaccination:_____

_____

Signature of Physician or School Official Date

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