SCRIPPS MERCY HOSPITAL, SAN DIEGO
Application for 4th Year Sub-Internship

1. Contact Debra Crandall, Internal Medicine Program Coordinator, to inquire about available dates: Crandall.Debra@scrippshealth.org or 619-260-7220

2. Send this completed application (sections I, II, and III) ***with the following attachments*** to Crandall.Debra@scrippshealth.org
   - Official letter of good standing from your school
   - A copy of your USMLE Step 1 score (passing score required prior to the start of your rotation)
   - A copy of your current health insurance
   - A copy or documentation from your school indicating you have cleared a background check
   - Letter from a faculty member or previous preceptor supporting your application (waived if you have done a 3rd year medicine core clerkship at Scripps Mercy San Diego)

Once your application has been reviewed by our 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.

SECTION I. TO BE COMPLETED BY STUDENT

First Name: _____ MI: _____ Last Name: _____

Date of Birth: ____/_____/_____ Social Security: _____ Phone Number: _____

Mailing Address: _____

Email Address: _____

Undergraduate College/University: _____ Degree: _____ Graduation Date: _____

Other Degrees or Advanced Education: _____

Honors or Awards _____

I am a registered 4th year medical student at applying for a sub-internship in Internal Medicine - Inpatient Wards. My expected graduation date is _____. I ☐ will ☐ will not apply for a residency position at Scripps Mercy Hospital in ☐ Internal Medicine or ☐ Transitional Year.

Preferred Dates for Rotation (*Contact Debra Crandall for available dates*)

First Choice: From _____ to _____

Second Choice: From _____ to _____

Please indicate 2-3 expectations and/or goals you wish you gain from this Sub-I experience:

Student's Signature: _____ Date: _____

Student's Name: _____

SECTION II. TO BE COMPLETED BY DEAN OF STUDENTS OR DESIGNATED OFFICIAL AT STUDENT'S SCHOOL

Core Course	# Weeks Completed	Date Completed
Medicine	_____	_____
Surgery	_____	_____
OBGYN	_____	_____
Pediatrics	_____	_____
Psychiatry	_____	_____
Other	_____	_____

Medical School Seal:

Seal Stamped Here

USMLE Step 1 (*Must have taken and passed*) Date Taken: _____ Score: _____

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, I have attached the form for return with the application

School Address:_____

School Phone: _____

School Official Name: _____ Title: _____

School Official Signature: _____ Date: _____

Student's Name: _____

SECTION III. TO BE COMPLETED BY A PHYSICIAN OR SCHOOL OFFICIAL

Verification of Immunizations

	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:

TUBERCULIN SKIN TEST: Must be taken within one year prior to the Scripps Mercy rotation.

Date: _____ Test: _____ Result: _____

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

TUBERCULOSIS RESPIRATOR: Have you ever been fitted for a TB respirator?

☐ No or not sure of brand/size. We will have you fit tested at check-in.

☐ Yes. Date tested _____ brand and size: _____

OTHER REQUIRED VACCINES:

Date of TDAP Vaccination: _____

Date of most recent Influenza Vaccination: _____

_____ _____

Signature of Physician or School Official Date