



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 want to accomplish at this rotation? _____

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

Administrative Contact: _____ Phone Number: _____

COMLEX 1 Score: _____ USMLE Score: _____

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

- | | |
|--|---|
| <input type="checkbox"/> Emergency Medicine | <input type="checkbox"/> Internal Medicine/Emergency Medicine |
| <input type="checkbox"/> Family Medicine | <input type="checkbox"/> Family Medicine/Emergency Medicine |
| <input type="checkbox"/> Internal Medicine | |
| <input type="checkbox"/> Not interested in an Aria residency | |

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**