MemorialCare
Long Beach Memorial Medical Center
Miller Children's Hospital

Long Beach Memorial Medical Center/Miller Children's Hospital Clerkship Application

Today's Date: ________________________

Name (please print)

____

Permanent Address: ________________________________ (City) _________________________ (State) _______(Zip) ___________

Home Phone Number (   ) ________________________ Cell (   ) _________________________ DOB ________/_______/______

Email Address: ____ Social Security Number:_________/_________/__________

U.S. Citizen: Yes: ________ No: ________ Other: ____________________ Place of Birth ________________________________

ROTATION DATES REQUESTED

Name of Program: ____ Rotation Specialty ______________________________

Name of Program Director ___________________________________ Location/Medical Center: LBMMC ☐ MCH ☐

Desired Dates of Clerkship:

First Choice: _________ to __________ **Second Choice:** __________ to _________ **Third Choice:** ________ to _________

Have you completed a previous clinical rotation with LBMMC/MCH? No _________ Yes___________

If yes, please specify date, location, specialty, and mentoring physician:

____

MEDICAL EDUCATION

Medical School ____

Address ______________________________(City) __________________(State) _________(Zip) ___________

Country ______________ Month/Year Start Date: _______________ Month/Year Anticipated/Graduation Date: ____________

Title: Medical Student _____________yr Specialty of Interest/Training ____

DOCUMENTS INCLUDED WITH THIS APPLICATION

	Enclosed
Current TB Test	Yes ____________
Proof of Flu Shot (if applicable)	Yes ____________
Proof of Current Health Screening (Immunizations)	Yes ____________
Malpractice Insurance Statement	Yes ____________

LBMMC OFFICE USE ONLY

Application Received:	**Reviewed by:**	**Approved** ☐ **Denied** ☐ **Date:** __________

PLEASE BRIEFLY STATE YOUR INTEREST IN COMPLETING YOUR CLERKSHIP AT LONG BEACH MEMORIAL FAMILY MEDICINE BELOW