Long Beach Memorial Primary Care Sports Medicine Fellowship
Resident Rotation Application Form

Please complete the form below and attach requested documents as well as a brief paragraph outlining your interest in sports medicine (Statement of Interest).
Please email all forms to: Kelly Ambrose at kambrose@memorialcare.org

PERSONAL DATA

Full Name: ____
Last First Middle

Present Mailing Address:

Street Address: ____

City:_________________________ State:______ Zip Code:______________

Telephone:
Home ( ) _______________ Work ( ) ________________Cell ( ) ________________

Email: ____

Required with application:

1. Letter of Recommendation from Your Program Director
2. CV
3. Malpractice Insurance Statement/Certificate
4. Copy of Photo ID
5. Proof of Current Health Screening (Immunizations, TB, Flu Shot)
6. Copy of Medical Health Insurance
7. Copy of Medical License

(You do not need a CA license, we will register you with the State of California when your application has been approved)

Have you:

- ☐ Been vaccinated against hepatitis B Virus,
- ☐ Proof of immunity against Hep B, or
- ☐ Formally declined vaccination.

US CITIZEN: YES_____ NO_____

If not a citizen:

- PERMANENT RESIDENT____
- J-1____
- H-1 ___
- OTHER (please specify) ____

EDUCATION

Undergraduate Education

Institution Name:____ Institution City/State:_____

Attended From: __________ To: __________

Degree awarded: ____

Graduate Education (Medical and Masters or Doctoral Program)

Institution Name:____ Institution City/State:_____

Attended From: __________ To: __________

Degree awarded: ____

Postgraduate Medical Education:

Internship: (if more than one, please provide additional information on a separate sheet)

____Institution

Specialty

From (Month/Day/Year):_____________________ To (Month/Day/Year):___________________

Residencies: (if more than one, please provide additional information on a separate sheet)

____Institution

Specialty

From (Month/Day/Year):_____________________ To (Month/Day/Year):___________________

Fellowships: (if more than one, please provide additional information on a separate sheet)

____Institution

Specialty

From (Month/Day/Year):_____________________ To (Month/Day/Year):___________________

DATES REQUESTED (2 WEEK INCREMENTS)

1st CHOICE:_______________________________

2nd CHOICE:_______________________________

3rd CHOICE:_______________________________

STATEMENT OF INTEREST (200-word limit)

Please describe your interest in the sports medicine elective and indicate whether you will be applying to a sports medicine fellowship in the future.