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:

Letter of Recommendation from Your Program Director

CV

USMLE/COMLEX Parts 1 & 2

Malpractice Insurance Statement/Certificate

Copy of Photo ID

Proof of Current Health Screening (Immunizations, TB, Flu Shot, Covid)

Copy of Medical Health Insurance

Copy of Medical License
(You do not need a CA license if you are out of state, 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.