**APPLICATION FOR MEDICAL/PA STUDENTS & VISITING RESIDENTS/FELLOWS**

***Name:***

 ***Last Name First Name Middle Initial***

***Address:***

 ***Street Number & Name City State Zip Code***

***Cell # Email DOB SS# (last 4)***

***Emergency Contact Name & Phone #:***

***Medical/PA School Name:***

***MS/PA Year: Graduation Date: Degree (to be) Awarded):***

***USMLE Step 1: USMLE Step 2 CK:***

 ***Attempts: \_\_\_\_\_\_\_\_ Attempts: \_\_\_\_\_\_\_\_***

 ***&/OR***

 ***COMLEX I: COMLEX II:***

 ***Attempts: \_\_\_\_\_\_\_\_ Attempts: \_\_\_\_\_\_\_\_***

***School Coordinator Name:***

***Professional Liability Insurance:***

***Insurance Carrier Name:***

***Rotation Dates Requested: First Choice: Second Choice:***

 ***Third Choice:***

***Elective Interest:***

***Office Use Only:***

***TriHealth Approval: (Residency Program Director, Dept. Chair, Preceptor, Supervising Physician, etc)***

***Approved (Y/N): Printed Name/Title:***

***Signature: Date:***

**Please also complete the questions on the following page**

Please Return Completed Form To:

Kerry Hatfield, GME Coordinator - Medical Students

Good Samaritan Hospital 3rd floor Room 0316

Cincinnati, Ohio 45220

Phone: 513-862-2255 - Email:Kerry\_hatfield@trihealth.com

*Thank you for your interest in rotating with our program!*

*To get to know you and your journey a little more, please answer the following questions.*

1. Why are you interested in OBGYN, Internal Medicine, or Surgery?
2. Why are you interested in our residency program at TriHealth?
3. What distinguishes you from other applicants?
4. What kind of practice setting/location do you see yourself in after Residency?
5. Have there been any interruptions/remediations with your medical school education? If so, why?