DEPARTMENT OF MEDICAL EDUCATION: STUDENT ELECTIVE APPLICATION

APPLICANT INFORMATION		
Name:	**Preferred Nickname:**	
Current Mailing Address:		
City:	**State:**	**Zip:**
DOB:	**SSN (Required for system setup):**	
Cell phone:	**Email Address:**	

EDUCATIONAL INFORMATION		
Undergraduate School:		
Medical School:		
Mailing Address:		
City:	**State:**	**Zip:**
School Contact Person Name and Phone Number:		
Expected Date of Graduation:		
Have you taken the USMLE Step One? If so, please indicate your score:		

ELECTIVE INFORMATION	
Elective Requested	**Please Rank Choices from 1-3**
Emergency Medicine	
Family Medicine in the Community Hospital	
Pediatrics: ☐ General ☐ PICU	
Surgery: ☐ General ☐ Cardiothoracic ☐ Trauma ☐ Oncological ☐ Vascular ☐ Orthopedic ☐ Plastic	
Internal Medicine:	
OB/GYN:	
Psychiatry:	
Rural Family Medicine:	
Other Elective Request:	
Other Elective Request:	

CLINICAL ROTATION DATES		
First Choice	**Second Choice**	**Third Choice**
Why are you interested in completing an elective at Spartanburg Regional?		
What is your primary residency interest?		
Please list medical school courses or rotations for which you have received the grade of honors (or equivalent):		

STUDENT SIGNATURE	
Signature of Applicant:	**Date:**

Please return this document by email to melowens@srhs.com or fax to (864) 560-6063.