Spartanburg Regional Healthcare System

SURGICAL: AUDITION ROTATION APPLICATION

CONTACT INFORMATION		
Name:		
Street Address:		
City, State:		**ZIP Code:**
Phone:		**Email:**
Hometown:		
Medical School:		
Date of Birth:	**SSN** *(Required for System Setup)*:	

AUDITION ROTATION DATES (August–January Only)		
1st Choice:	**2nd Choice**:	**3rd Choice:**

SURGICAL AUDITION ROTATION PREFERENCE
1st Choice:
2nd Choice:
3rd Choice:
4th Choice:
5th Choice:

EDUCATIONAL BACKGROUND		
What are your scores?	**USMLE:**	**Comlex:**
Have you failed any rotations or classes?	☐ Yes ☐ No	

If yes, please indicate and describe:

Tell us why you are interested in completing a surgical audition rotation at SRHS:

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