

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: <input type="checkbox"/> General <input type="checkbox"/> PICU		
Surgery: <input type="checkbox"/> General <input type="checkbox"/> Cardiothoracic <input type="checkbox"/> Trauma <input type="checkbox"/> Oncological <input type="checkbox"/> Vascular <input type="checkbox"/> Orthopedic <input type="checkbox"/> 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 kimberly.harris@srhs.com.