BalladHealth
It's your story. We're listening.
Johnston Memorial Hospital

Revised 6/11/2020

Please complete this form in its entirety to request your audition rotation. Applications will be reviewed by the FM and IM residency programs. Incomplete applications will not be considered.

Student Name_____

Students applying for audition rotations must be in their final year of medical school. All items on this checklist must be submitted at the time of application. **Incomplete applications will not be processed until all documents on the check list are received.**

A complete application will contain:

Application Form

___ Student Component

Health Forms & Proof of Health Insurance

___ Complete Immunization Record with appropriate signature (health care provider or student health office) including TB skin test.

Copy of current BLS Card

___Copy of Active BLS Cards

Criminal Background Check (please include one)

___Provided by my school—attach a letter or statement to this effect.

OR

___ I've started the process by contacting my local police station or the FBI or by contacting an online vendor. Documentation is attached.

CV

___ Up to date CV with Picture

I confirm that all mentioned above are enclosed in this packet. Failure to enclose all required documents will result in a delay in the processing of your application.

Student Signature: _____

Date:_____

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Changes in Audition Rotation: Once a student has been scheduled to rotate, no change in audition rotation choice or rotation block will be allowed. This policy cannot be overridden by a department or an attending.

Cancellation Policy: If you can no longer attend your approved audition rotation which you have accepted, you must notify the Medical Student Clinical Coordinator via email no later than 4 weeks prior to your start date. The Medical Student Clinical Coordinator will then notify the department that you cannot attend. No re-scheduling of audition rotation is permitted if you fail to notify the Medical Student Clinical Coordinator at least 4 weeks prior to your start date.

*****PLEASE DO NOT CONTACT PRECEPTORS OR PRECEPTOR OFFICES FOR ANY REASON DURING THE APPLICATION PROCESS. CONTACTING ANY OF THESE PARTIES MAY RESULT IN YOUR INELIGIBILITY FOR CURRENT AND FUTURE ROTATIONS*****

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Audition Rotation Application

STUDENT COMPONENT

Name:_____
First **Middle (Required for computer access)** **Last**
Not initial but actual name

Date of Birth:_____ **Cell Phone:**_____

Last 5 Digits of your Social Security Number:_____
(Required for Computer Access)

Email:_____

Medical School:_____

COMLEX I:_____ **COMLEX II:**_____ **COMLEX PE:**_____
(or date scheduled) **(or date scheduled)**

*Attempts:*_____ *Attempts:*_____ *Attempts:*_____

OR

USMLE Step 1:_____ **USMLE Step 2 CK:**_____ **USMLE Step 2 CS:**_____
(or date scheduled) **(or date scheduled)**

*Attempts:*_____ *Attempts:*_____ *Attempts:*_____

AUDITION ROTATION DATES REQUESTED
All rotations are 4 week rotations. No Exceptions.
Please select up to 3 options and rank them in order from 1 to 3; 1 being your preferred rotation.

_____8/31 to 9/25/20

_____9/28 to 10/23/20

_____10/26 to 11/20/20

_____11/23 to 12/18/20

_____1/4 to 1/29/20

_____2/1 to 2/26/20

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Please indicate which Residency program you are interested in applying:

Family Medicine

Internal Medicine

QUESTIONS

Attach additional sheets if necessary.

1. Why are you interested in family/internal medicine?

2. Why are you interested in a residency program at Johnston Memorial Hospital?

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/remediation with your medical school education? If so, why?

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School Contact for Affiliation Agreement

Contact Name:_____

Email Address:_____

Phone Number:_____

NOTE: AFFILIATION AGREEMENT IS NON-NEGOTIABLE AND WILL NEED TO BE SIGNED AS APPROVED BY BALLAD LEGAL DEPARTMENT.

Completed applications should be sent to:
Heather Musick, Medical Student Clinical Coordinator
Johnston Memorial Hospital, Office of Student Medical Education
Heather.musick@balladhealth.org

Medical Education Use ONLY

Date Request Received by Office:_____

- Approved
- Declined

Authorized Department Initials:_____

Notes: