

Department of Medicine **Student Clerkship Application**

Thank you for your interest in the Internal Medicine Clerkship Program at St. Mary's Medical Center in San Francisco. If you are a current medical student interested in applying for a four-week sub-internship or elective rotation in the Department of Medicine, please submit the following:

- Application for Clerkship (Attachment A & B)
- Medical Student Contact Information (Attachment C)
- Current Copy of TB Test
- Current CV
- Half-page Summary: Please describe your specific interest in Internal Medicine, and include your reasons for wanting to participate in an elective rotation at St. Mary's Medical Center. We also recommend you take this opportunity to include important information about yourself that you would like to share with our Program Director Dr. Terrie Mendelson.

Send Application: To expedite the application process, please submit paperwork by fax or email
Fax: (415) 750-8149 (Recommended)
Email: Kathy.banks@chw.edu

Mail: St. Mary's Medical Center
Department of Medical Education
Attn: Kathy Banks
450 Stanyan Street
San Francisco, CA 94117

Clerkships are scheduled from August 1 through April 30. Please note we require a medical student affiliation with your school prior to final approval of your rotation. In addition, each rotating student must complete our hospital's mandatory background clearance at least 2-3 weeks in advance of the rotation start date.

Due to the processing time for these agreements, we advise you to reserve refundable airline tickets in the event your school's contract is not finalized by the deadline. We do our best to accommodate students with preferred dates, however, clerkship rotations are prioritized on a first come first serve basis. We do not charge a fee for this elective rotation. Students are provided with complimentary lunch and on-call meals. We do not provide student housing. Please note that we do not sponsor observerships for international medical graduates.

If you are approved to participate in our internal medicine clerkship program, you will receive a letter confirming your dates of rotation. We hope the clerkship fulfills your elective rotation goals while making your stay with SMMC a memorable experience.

Kathy Banks
Program Coordinator
Internal Medicine Residency Program
St. Mary's Medical Center
450 Stanyan Street, San Francisco, CA 94117
Tel: 415-750-5781 Fax: 415-750-8149 Email: kathy.banks@chw.edu



St. Mary's Medical Center
Internal Medicine Residency Program
450 Stanyan Street
San Francisco, CA 94117

Re: Student Elective Rotations – Sub-I Internal Medicine

We are delighted that you are interested in doing a Sub-I clerkship in Internal Medicine at St. Mary's Medical Center. The Medicine Program currently offers 4-week rotations based on pre-approval from our Program Director. Your request must be submitted in writing at least 3 months in advance to our department for pre-authorization.

Instructions: Complete student information below and SECTION I of the Application for Clerkship. Forward completed application form to your Student Affairs Office to complete the SECTION II. Once complete, fax to our office at (415) 750-8149. Upon receipt and approval of all required information, you will be emailed confirmation.

Note: *An Institutional affiliation agreement between St. Mary's Medical Center and the Medical School must be in effect prior to undertaking an elective.*

PLEASE PROVIDE THE FOLLOWING INFORMATION:

Medical School/Hospital/Facility: _____

Contact Name/Title: _____
(Authorized to sign agreement)

Mailing Address: _____

Phone: _____ **Fax:** _____

Email: _____

Additional information about our Internal Medicine Residency Program is available on our Web site at **www.stmarysmed.org**.

If you have further questions or require additional information, please feel free to contact our Program Coordinator, Kathy Banks at (415) 750-5781 – Fax (415) 750-8149.

APPLICATION FOR CLERKSHIP – Internal Medicine

SECTION I: *To be completed by student – (please print or type).*

I would like to apply for an elective clerkship during the following Academic Year:

From _____ to _____, 2009

Requested Rotation Dates: (From/To)

_____ 1st Choice _____ 2nd Choice _____ 3rd Choice

Student's Name: _____ Phone: _____
Residence

Address: _____
Cell

City/State/Zip: _____ Email: _____

SECTION II: *To be completed by Dean or authorized official of student's medical school on school letterhead with address and contact numbers.*

A dated letter from the Dean stating that the above named student will be in his/her _____ year of medical school, and remains in good standing and meets all the requirements to participate in our elective clerkship rotation. Additionally, this same letter must certify that the following is true:

- Malpractice insurance covers the student away from his/her school.
- Personal health insurance coverage is in effect away from his/her school.
- At the conclusion of the clerkship, an evaluation form will be provided by his/her school for completion by the clerkship Director.

SMMC Internal Medicine Clerkship Program

MEDICAL STUDENT CONTACT INFORMATION

Please complete and submit with your application.

Name:	
Medical School:	
Home Phone:	Cell:
Email:	
Dates of Rotation:	
Emergency Contact Information	
Name:	Phone:
Relationship to Student:	

**Below information is for office use only:

- | | |
|--|---|
| <input type="checkbox"/> Copy of current TB
<input type="checkbox"/> Copy of student ID
<input type="checkbox"/> Medical student contract
<input type="checkbox"/> Certificate of Insurance | <input type="checkbox"/> CV/Summary Collected
<input type="checkbox"/> Background Clearance
<input type="checkbox"/> Program Evaluation
<input type="checkbox"/> Final Confirmation Letter |
|--|---|