



**DEPARTMENT OF GRADUATE MEDICAL EDUCATION
615 SOUTH NEW BALLAS ROAD
ST. LOUIS, MO 63141**

APPLICATION FORM FOR RESIDENT/FELLOW ROTATIONS*

(Please print)

PERSONAL DATA:	
Name:	Birthdate: City and State of Birth:
Address:	Citizenship: Male <input type="checkbox"/> Female <input type="checkbox"/>
City/State/Zip	ECFMG #/Date:
Phone # Home: Cell:	EMAIL ADDRESS:
Social Security #:	Single <input type="checkbox"/> Married <input type="checkbox"/> Spouse Name:

EDUCATION :	RESIDENCY TRAINING:
Current University or College:	Residency Training Hospital:
Dates Attended: Degree Awarded:	Department:
Medical School:	Address:
Date entered: Date Completed:	City/State/Zip
Current Level of Training:	Current Level of Training: Dates of Training:
Contact Name & Phone Number	Missouri License Number:

HEALTH DATA:	
Immunization Status:	
1) Have you had Diphtheria-Tetanus Booster within the past ten (10) years? Yes <input type="checkbox"/> No <input type="checkbox"/>	2) Have you had the Hepatitis B Vaccine series recommended by your Training Program? Yes <input type="checkbox"/> No <input type="checkbox"/>

SIGNATURE OF APPLICANT:	DATE:

MUST BE FILED AT LEAST 8 WEEKS IN ADVANCE*
(OVER)

ROTATION (s) REQUESTED AND DATE(s):

Dates of requested rotation: Please complete a separate form for each request and mail the form(s) to the address below. That department will notify you if you have been approved.

Service Requested:	Requested Month/Year	Rotation Requested:	Requested Month/Year
Anesthesiology Contact: Gertrude Email to: barrgg@mercy.net Phone No. 314-251-7546 Fax No. 314-251-4169	_____/ _____	Family Medicine 12680 Olive Blvd. , St. Louis, MO 63141 Contact: Shimali Email to: premss@mercy.net Phone No. 314-251-8950 Fax No. 314-251-8889	_____/ _____
Cardiology Contact: Michelle Email to: kempml@mercy.net Phone No. 314-251-5834 Fax No. 314-251-6272	_____/ _____	Internal Medicine – Suite 3019B Contact: Michelle Email to: kempml@mercy.net Phone No. 314-251-5834 Fax No. 314-251-6272	_____/ _____
Critical Care Contact: Susan Email to: elliss@mercy.net Phone No. 314-251-1360 Fax No. 314-251-5721	_____/ _____	OB/GYN – Suite 2009B Contact: Kay Email to : edwarokr@mercy.net Phone No. 314-251-6826 Fax No. 314-251-6918	_____/ _____
Emergency Medicine Contact: Charlene Email to: talicc@mercy.net Phone No. 314-251-6816 Fax No. 314-251-1601	_____/ _____	Surgery – Suite 7049 Contact: Terri Email to: browte@mercy.net Phone No. 314-251-5834 Fax No. 314-251-4328	_____/ _____
	_____/ _____		

St. John's Mercy Medical Center	
Preceptor's Name and Signature _____	_____
Print Name	Signature
Date: _____	

Please return to: St. John's Mercy Medical Center
 Attn: _____
 (Insert Dept., Ste. and Name from above)
 615 South New Ballas Road
 St. Louis, Missouri 63141

Requirements: An affiliation agreement between your Institution and St. John's Mercy Medical Center. After you have been approved, please contact the department contact person listed above.

Website address: www.sjmmcgme.com