



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

**APPLICATION FORM FOR ELECTIVES/EXTERNSHIPS\***

(Please print)

<b>PERSONAL DATA:</b>	
Name:	Birthdate: <span style="float: right;">City and State of Birth:</span>
Address:	Citizenship: <span style="float: right;">Single <input type="checkbox"/> Married <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/></span>
City/State/Zip	EMAIL ADDRESS:
Home Phone:	Parents Name:
Cell Phone:	Parents Address:
Social Security #:	Parents Telephone #:

<b>EDUCATION :</b>	
Current University or College:	
Dates Attended:	Degree Awarded:
Medical School:	
Date entered:	Current level of Training:
School contact Name:	School contact Number:

<b>HEALTH DATA:</b>	
<b>Immunization Status:</b>	
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 School? Yes <input type="checkbox"/> No <input type="checkbox"/>

<b>SIGNATURE OF APPLICANT:</b>	<b>DATE:</b>

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

**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.**

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

IS THIS EXTERNSHIP FOR CREDIT? YES  / NO

St. John's Mercy Medical Center

Preceptor's Name and Signature \_\_\_\_\_ and \_\_\_\_\_  
 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

Student requirements: Please submit a letter from your school stating that you are in good standing and the school will cover your malpractice/liability insurance while rotating @ St. John's. (Submit the letters with this form directly to the department you would like to rotate in.)

Questions regarding all rotations should be directed toward each individual department.

Website address: [www.sjmmcgme.com](http://www.sjmmcgme.com)