



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

Re: Orthopaedic Surgery Student Elective Rotations

We are delighted you are interested in doing an Orthopaedic clerkship at St. Mary's Medical Center. Our orthopaedic surgery elective clerkship program currently **only** offers consecutive (4) four week rotations. Once your application is received it will be reviewed for approval by our program director. Upon approval you will be notified of acceptance to participate in our clerkship program.

Instruction to Students: Fill out the student information page below and requested rotation dates. Once completed forward this form to your Student Affairs Office to complete their portion and fax to our office at (415) 750-5938. Upon receipt and approval of all required information, confirmation will be emailed to you.

***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 Orthopaedic Residency Program is available on our web site  
[www.stmarysmedicalcenter.org/residencies\\_and\\_fellowships](http://www.stmarysmedicalcenter.org/residencies_and_fellowships)

If you have further questions, or require additional information, please feel free to contact our Program Coordinator, Ayana Matthews at (415) 750-5782 – Fax (415) 750-5938 or via email [ayana.matthews@dignityhealth.org](mailto:ayana.matthews@dignityhealth.org)

## APPLICATION FOR CLERKSHIP Orthopaedic Surgery

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 \_\_\_\_\_, 20\_\_\_\_\_

Our scheduling begins at the start of each month. If the 1<sup>st</sup> day of the month occurs during mid-week, we'll start on the first Monday following.

Requested Rotation Dates: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
(From/To) 1<sup>st</sup> Choice 2<sup>nd</sup> Choice 3<sup>rd</sup> Choice

Students Name: \_\_\_\_\_ Phone: \_\_\_\_\_

(Residence)

Address: \_\_\_\_\_

(Cell)

City/State: \_\_\_\_\_ Email: \_\_\_\_\_

Section II: To be completed by Dean or authorized official of student's medical school

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.

The following is certified:

1. Malpractice insurance covers the student away from this school
2. Personal health insurance coverage is in effect away from this school
3. At the conclusion of the clerkship, an evaluation will be provided for completion by Program Director

AUTHORIZED BY: \_\_\_\_\_

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Please print

Name of School: \_\_\_\_\_

Address: \_\_\_\_\_

City/State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_