St. Mary's Medical Center
A Dignity Health Member

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

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

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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 1st day of the month occurs during mid-week, we'll start on the first Monday following.

Requested Rotation Dates:_____-_____ _____-_____ _____-_____
(From/To) 1st Choice 2nd Choice 3rd 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:_____