

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

**APPLICATION**

**ELECTIVES/EXTERNSHIPS**     **OBSERVERSHIP**     **RESIDENT/FELLOW ROTATIONS\***

(Please print-follow directions carefully incomplete forms will not be processed)

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

<b>EDUCATION :</b>	<b>RESIDENCY TRAINING:</b>
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:

<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>

I am Requesting an:    **ELECTIVE**        **EXTERNSHIP**        **OBSERVERSHIP**   

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) directly to the address below (please add in the department name). That department will notify you if you have been approved.**

**\*PLEASE NOTE: Additional Information is required for Internal Medicine Rotations only. (email Michelle below)**

Service Requested:	Requested Month/Year	Rotation Requested:	Requested Month/Year
<b>Cardiology</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>Family Medicine</b> <b>12680 Olive Blvd. , St. Louis, MO 63141</b> Contact: Kristin South Email to: <a href="mailto:Kristin.South@mercy.net">Kristin.South@mercy.net</a> Phone No. 314-251-8950 Fax No. 314-251-8889	_____/_____ _____/_____
<b>Critical Care</b> Contact: Cami Email to: <a href="mailto:Cameron.compton@mercy.net">Cameron.compton@mercy.net</a> Phone No. 314-251-1360 Fax No. 314-251-5721	_____/_____ _____/_____	<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>Emergency Medicine</b> Contact: Janie Erb Email to: <a href="mailto:Maryjane.Erb@Mercy.net">Maryjane.Erb@Mercy.net</a> Phone No. 314-251-6816 Fax No. 314-251-1601	_____/_____ _____/_____	<b>OB/GYN – Suite 2009B</b> Contact: Anne Email to : <a href="mailto:Anne.Fitzwilliam@mercy.net">Anne.Fitzwilliam@mercy.net</a> Phone No. 314-251-6462 Fax No. 314-251-4492	_____/_____ _____/_____
<b>Surgery – Suite 7049</b> Contact: Teri Email to: <a href="mailto:teri.brown@mercy.net">teri.brown@mercy.net</a> Phone No. 314-251-5898 Fax No. 314-251-4328	_____/_____ _____/_____	<b>Burn Center – Suite 7049</b> Contact: Teri Email to: <a href="mailto:teri.brown@mercy.net">teri.brown@mercy.net</a> Phone No. 314-251-5898 Fax No. 314-251-4328	_____/_____ _____/_____

This section for (St. John’s Mercy office use only)	
IS THIS EXTERNSHIP FOR CREDIT? YES <input type="checkbox"/> / NO <input type="checkbox"/>	Date: _____
St. John’s Mercy Medical Center Preceptor’s Name and Signature _____ and _____ <div style="display: flex; justify-content: space-between; width: 100%;"> <span>Print Name</span> <span>Signature</span> </div>	

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

**NOTE: the following must be submitted with your application.**

**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 to each individual department.**

Website address <http://www.mercy.net/careers/graduate-medical-education>