Please complete this form in its entirety to request your addition rotation. Incomplete Applications will not be processed. Once your request is received you will be notified by email if your request has been approved. Rotations are subject to Cancellation if Medical School Documentation is not received within 30 days of your start date

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

Cell Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Class Rank: \_\_\_\_\_\_\_\_\_\_\_\_\_ GPA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

USMLE/COMLEX I: \_\_\_\_\_\_\_\_\_\_ USMLE CK/COMLEX II CE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ USMLE CS/COMLEX II PE: \_\_\_\_\_\_\_\_\_\_\_\_

Any Failures: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (If not taken, please indicate date scheduled)

Audition Rotation Dates Requested:

 Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ End Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ End Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ End Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Will you require shared housing? YES/NO If yes, indicate Male or Female for housing purposes

1. Why are you interested in Family Medicine?
2. Why are you interested in the Family Medicine Residency Program at UPMC Horizon?
3. What distinguishes you from other applicants?
4. What kind of practice setting/location do you see yourself in after residency?
5. Have there been any interruptions with your medical school education? If so, why?

**Completed application along with your CV should be sent to**

**Aleesa Foltz at** **foltzaa@upmc.edu**

**Graduate Medical Education – UPMC Horizon**

**2200 Memorial Drive**

**Farrell, PA 16121**

Medical Education Use Only

Date requests received by office:

Approved: Y\_\_\_\_ N \_\_\_\_\_

Date Med Student Emailed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_