

Work History: (fully describe any time (6 months & over) between medical school graduation date and start of current residency program. prior residency program, travel, private practice family obligations etc.) (Give exact dates).

ACLS Expiration Date ATLS: Expiration Date) _____

Local Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Phone # _____ **E-mail** _____ **Pager** _____

EMERGENCY CONTACT:

Name: _____ **Relationship** _____ **Phone #** _____

***Have you ever been charged with a violation if any statue of any state, the US or any Foreign country
If yes, Please Explain:** _____

NOTE: In compliance with Arizona State Public Health laws it is mandatory that all personnel provide evidence of immunity to TB, Rubella, Rubeola, Hepatitis B and Varicella before reporting to assigned duties. A copy of your immunization record is required.

I herby certify that the information I submit in this application is complete and correct to the best of my knowledge and belief.

Applicant Signature _____
Date

Program Director/Coordinator Signator _____
Date



Banner Health System

Banner Good Samaritan Medical Center Elective Request Form

Away electives may not be done in June of the senior year. Electives may only be taken after 50% of core electives have been completed and scheduled. The following items must be specified.

Resident Name: _____

Pager: _____ **Email:** _____

Rotating Institution: _____

Name of Rotation: _____

Start/End Date of Rotation: _____
Month/Day/Year

Attending Physician: _____

Address: _____

Contact Person: _____

Phone # _____ **Fax #** _____

1. Purpose of the elective (i.e. educational goals and objectives)

2. Curriculum

3. Schedule of Hours

4. _____ **Clinic Director Signature** _____ **Date**

5. _____ **Program Director Signature** _____ **Date**

6. **Date of RAC Approval** _____

To be Completed by Internal Medicine Department

COPIES TO:

Department File ___ **Jr. Faculty** ___ **Clinic** ___ **Resident** ___

DOCUMENTS REQUIRED TO ACCOMPANY APPLICATION:

- Proof of Malpractice (Dept) _____
- Letter of Good Standing (Dept) _____
- *Current Vaccination Records (Resident to contact Occupational Health 239-4456) _____
- *Copy of Resident's Training Permit (Resident) _____
- Rotation Evaluation (Dept) _____

*** Resident's Responsibility to Obtain**

Completed Evaluation Returned by Resident _____
Date Returned