

NOTE: Please type or print clearly all entries

HOSPITAL
FOR
SPECIAL
SURGERY

Application For Clerkship

DEPARTMENT
OF
RADIOLOGY
AND
IMAGING



Medical Student

Resident

SECTION I: TO BE COMPLETED BY STUDENT/RESIDENT

Name:	Medical School/Training Program:	
Address:	School Address:	
Phone:	E-mail:	
Dean/Program Director Name:	Dean/Program Director Phone :	Dean/Program Director E-mail:
Applicant Signature:	Date:	
Preferred Dates of Elective:	Alternate Dates:	

SECTION II: TO BE COMPLETED BY AUTHORIZED OFFICIAL OF STUDENT'S SCHOOL/PROGRAM

The above named student is in good standing at this institution. At the time of requested elective, the student will be in his/her _____ year of a _____ year program.

The student (will) (will not) pay tuition at our school during the period indicated.

Personal health coverage (is) (is not) in effect while the student is away from school/program.

Malpractice insurance (is) (is not) in effect while the student is away from school/program.

The student is approved to take this elective (for credit) (not for credit).

At the end of the clerkship, and evaluation (will) (will not) be required.

IF A SPECIFIC EVALUATION FORM IS REQUIRED, PLEASE ATTACH

Print Name:	Signature:
Date:	Print Title:

PLEASE NOTE: ALL APPLICANTS MUST SUBMIT THE FOLLOWING:

1. CVA
2. A completed health statement – This can be obtained on Page 3 and Page 4 of the following link:
http://intranet.hss.edu/departments/education/2010/files/AVO_Application05.2010.pdf

Please Return All Materials To :

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