

**APPLICATION FOR TRADITIONAL INTERNSHIP PROGRAM**

NAME \_\_\_\_\_ SS# \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

          LAST                FIRST

ADDRESS \_\_\_\_\_

HOME PHONE \_\_\_\_\_ MESSAGE PHONE \_\_\_\_\_ MALE \_\_\_\_\_ FEMALE \_\_\_\_\_

MARITAL STATUS \_\_\_\_\_

HIGH SCHOOL \_\_\_\_\_ GRADUATION DATE \_\_\_\_\_

COLLEGE \_\_\_\_\_ GRADUATION DATE \_\_\_\_\_

MEDICAL SCHOOL \_\_\_\_\_ GRADUATION DATE \_\_\_\_\_

NATIONAL BOARDS: PART TAKE \_\_\_\_\_ DATE \_\_\_\_\_

**EXTERNSHIPS**

HOSPITAL AND ADDRESS \_\_\_\_\_ FROM \_\_\_\_\_ TO \_\_\_\_\_ TYPE \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

INTERNSHIP: HOSPITAL AND ADDRESS \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**PREVIOUS EMPLOYMENT** (List Latest Position First)

FROM	TO	NAME OF EMPLOYER	ADDRESS	POSITION
------	----	------------------	---------	----------

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**LIST 3 REFERENCES TO BE CONTACTED**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**THE FOLLOWING MUST ACCOMPANY APPLICATION:**

Two letters of recommendation  
Medical School Transcript  
Board Scores

**IF NOT A CITIZEN OF THE UNITED STATES, DO YOU HAVE THE RIGHT TO REMAIN PERMANENTLY AND WORK IN UNITED STATES \_\_\_\_\_**

**IMMIGRATION STATUS \_\_\_\_\_**

**I understand and agree, if appointed by St. John's Episcopal Hospital, South Shore to faithfully perform in all respects all of the duties assigned to me, and to observe all the rules and regulations of the Hospital and American Osteopathic Association as now, and which will hereafter be established, and that I will faithfully serve for the duration of the term for which I am appointed. I understand that my services must be wholly satisfactory to the Hospital and its decision shall at all times be final as to continuance or termination of my services at the Hospital.**

**I agree to physical and medical examinations at any time at the option of the Hospital, at no personal expense, and agree that examining physician may disclose to the Hospital or its representatives the results of such examination. I give permission to contact all or any previous references for full information.**

**Further, I understand that as a Intern at St. John's Episcopal Hospital, South Shore, I will have Federal and State taxes and Social Security payments withheld from my check. I further understand that I will receive fringe benefits: namely work compensation, New York State Disability, Blue Cross, Blue Shield Major Medical and Dental benefits for myself.**

**All of the foregoing information I have supplied in this application is a full and complete statement of the facts and it is understood that if any falsification be discovered, it will constitute grounds for dismissal upon discovery thereof.**

**SIGNED \_\_\_\_\_ DATE: \_\_\_\_\_**

**ACTION ON INTERNSHIP APPLICATION**

**DATE INTERVIEWED \_\_\_\_\_ INTERVIEWED BY: \_\_\_\_\_**  
**RECOMMENDATION:**

**MEDICAL EDUCATION COMMITTEE**  
**FINAL ACTION \_\_\_\_\_**

**\_\_\_\_\_  
DIRECTOR OF MEDICAL EDUCATION**