



EMERGENCY ULTRASOUND RESIDENT ELECTIVE



APPLICANT INFORMATION			
Last Name	First	M.I.	Date
Street Address		Apartment/Unit #	
City	State	ZIP	
Phone	E-mail Address		
Elective Week Request 1.	2.	3.	
Are you a citizen of the United States?	YES <input type="checkbox"/> NO <input type="checkbox"/>	If no, are you authorized to work in the U.S.?	YES <input type="checkbox"/> NO <input type="checkbox"/>
Have you ever been convicted of a felony?	YES <input type="checkbox"/> NO <input type="checkbox"/>	If yes, explain	
EDUCATION			
College	Address	Dates Attended	
Medical School	Address	Dates Attended	
Internship	Address	Dates Attended	
Residency	Address	Dates Attended	
Other	Address	Dates Attended	
REFERENCES			
<i>Please list Program Director</i>			
Full Name	Institution		
E-mail	Phone ()		
DISCLAIMER AND SIGNATURES			
I certify that my answers are true and complete to the best of my knowledge.			
I understand that false or misleading information in my application may result in release from the rotation.			
Applicant Signature		Date	
I certify that _____ fulfills all of the following:			
(Applicant)			
1. Is a resident in good academic standing			
2. Is covered by his/her own institutional malpractice insurance policy			
3. Has cleared pre-employment and ongoing employee health requirements			
Program Director Signature		Date	