

**Jefferson Health – Northeast  
Visiting Medical Student Application**

Name: \_\_\_\_\_  
First
Middle
Last

Date of Birth: \_\_\_\_\_

Email Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Specialty Program Requested: \_\_\_\_\_

Requested Rotation Start Date: \_\_\_\_\_ Rotation End Date: \_\_\_\_\_

Alternate Rotation Dates: \_\_\_\_\_

***\*IF THIS IS AN AUDITION ROTATION, PLEASE LET US KNOW SO THAT WE CAN PLAN YOUR ROTATION ACCORDINGLY.***

Is this an audition rotation?     YES       NO

What do you hope to accomplish at this rotation? \_\_\_\_\_  
 \_\_\_\_\_

Medical School: \_\_\_\_\_ Year of Graduation: \_\_\_\_\_ / \_\_\_\_\_  
Month/Year

Administrative Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

COMLEX 1 Score: \_\_\_\_\_ USMLE Score 1: \_\_\_\_\_

COMLEX 2 Score: \_\_\_\_\_ USMLE Score 2: \_\_\_\_\_

Do you plan to apply for a Jefferson Health – Northeast residency? If interested, please indicate below.

- |   |  |
|---|--|
| <input type="checkbox"/> Emergency Medicine<br><input type="checkbox"/> Family Medicine<br><input type="checkbox"/> Internal Medicine | <input type="checkbox"/> Not interested in an Aria residency<br><input type="checkbox"/> Internal Medicine/Emergency Medicine<br><input type="checkbox"/> Family Medicine/Emergency Medicine |
|---|--|

Additional Information: \_\_\_\_\_  
 \_\_\_\_\_

Email completed application to: [StudentsJNE@jefferson.edu](mailto:StudentsJNE@jefferson.edu)

\*No other documents are required until approved. For more information, call 215-612-4609.