GRIFFIN HEALTH

Thank you for your interest in our Observer-ship Program at Griffin Hospital. Please read and review the following:

Criteria to be considered for observer-ship:

- Medical school graduate – attach copy of medical school diploma (+English translation)
- ECFMG certified – attach copy of certificate
- Score of 220 or above in Step 1 and Step 2 - attach copy of USMLE results
- 2 letters of recommendation – attach copies of signed and dated letters

Required forms:

- Completed Common Application (INCLUDE ALL ATTACHMENTS)
  - Immunization records - MMR and Varicella Titers, PPD within one year if negative, chest x-ray within 3 years if test positive. Proof of flu shot during flu season (Oct-March)
  - Copy of IDs (Passport+ driver's license if own)
  - Copy of valid visa
  - Proof of health insurance - must provide if selected
  - Signed copy of guidelines
- Completed Personal Information Form
- Other attachments required:
  - Copy of medical school diploma
  - Copy of ECFMG certificate
  - Copy USMLE scores
  - 2 LORs

All applications are to be EMAILED to observership@griffinhealth.org **(subject line Observership Application and your name)**
EMAIL DOCUMENTS IN WORD OR PDF FILE, JPG does not work in our system.

Griffin Hospital's Observership Program is highly competitive so all requirements are strictly adhered to and there are no exceptions. Please be sure that your application is **complete**. You will not be informed of any missing documents, and your application will be considered. **Please note: because of a high volume of applications, we are not able to respond to each applicant individually. If you are selected to participate in our program, you will be contacted via email.**

For further information, please visit our website at http://griffinmeded.org/Clinical-Observership

Additional Information

- We offer rotations in general medicine, cardiology and intensive care. We do not offer any other rotations. We are only able to accommodate 1 rotation (4 weeks) per applicant.

- Application period is August 1 through September 30 of each year. We accept applications during this time period only unless there are unfilled positions available. All complete applications will be reviewed.

- The cost of the program is $750.00 for a one month rotation, which is not due unless accepted and scheduled for a rotation. Payment must be made at least a month prior to the start of the rotation. Late payments are not accepted.

- We do not offer any rotations during the month of July.

- The rotation provides hands on experience in a hospital setting. Observer will be part of a team with 1 other learner, interns, resident and an attending. Observers will participate in daily educational activities which include didactics, teaching rounds, noon conferences, grand rounds etc. Observers will receive a more detailed schedules when selected for a rotation.

- Once selected, applicants will receive their acceptance letters along with their daily schedules via email.

- Because of a high volume of applications, we are not able to respond to each applicant individually. If selected, you will be contacted via email. Please refrain from sending repeated emails to check the status of your application.

GRIFFIN HOSPITAL
OBSERVERSHIP PROGRAM

PERSONAL INFORMATION FORM

Name_____
(Last) (First) (Middle)

Present Address: _____

_____

Cell# _____ Home#_____

Email Address: _____

Home Address: _____

Social Security # _____ Gender_____ State of Health_____

Date of Birth:_____ Place of Birth _____

In case of Emergency Contact:
Name: _____

Address: _____

Cell# _____ Home#_____

Previous Hospital Experiences:

Hospital	Position	Dates
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please indicate your choice of rotation in order of preference and list at least 3 months as available options for this rotation. Please note: we do our best to accommodate all applicants but your requested rotation is not guaranteed.

Rotation Desired: General Medicine__ ICU__ Telemetry__
Rank 1st, 2nd, and 3rd

Dates Preferred: Month 1: _____

Month 2: _____

Month 3: _____

COMMON APPLICATION FORM

Profile

Last Name: _____ Middle Initial: __ First Name: _____

Suffix: _____ Previous Last Name:_____ Preferred Name:_____

Contact E-Mail: _____

SSN (if applicable): _____ Passport or Visa #_____

Cell/Mobile#_____

Citizenship:

___US Citizen ___Permanent Resident ___Refugee/Asylum/Displaced
___ Foreign National ___Conditional Permanent Resident

Current & Expected Visa Types: (For Foreign nationals only – select all that may apply)

__ **B-1 –** Temporary visitor for business
__ **B-2** – Temporary visitor for pleasure
__ **F-1 –** Academic Student
__ **F-2** – Spouse or child of F-1
__ **H-1** – Temporary Worker
__ **H-1B** - Specialty Occupation, DoD worker, etc
__ **H-2B –** Temporary Worker-skilled and unskilled
__ **H-4 –** Spouse or child of H-1, H-2, H-3
__ **J-1** - Visa for exchange visitor
__ **J-2 –** Spouse or child of J-1
__ **O-1** - Extraordinary ability in sciences, arts education, business, or athletics.
__ **TN –** NAFTA trade visa for Canadians and Mexicans
__ **E-2 –** Treaty investor, spouse and children
__ **Diplomatic Service**
__ **Immigrant**
__ **EAD –** Employment Authorization
__ **Other**

Present Mailing Address/Contact Information:

Street Address: _____

City: _____ State/Province: _____

Zip Code: _____ Country: _____

Preferred Phone #: _____ Cell/Mobile: _____

Fax: _____ Pager: _____

Emergency Contact: Name_____ Cell/Phone # _____Relation_____

General Information:

Birth Place: CITY: _____COUNTRY: _____

Birth Date: _____ Female: _____ Male: _____ HEALTH STATUS: _____

Permanent Mailing Address:

Country: _____

Street Address: _____

City: _____ State/Province: _____ Zip Code:_____

Phone Number: _____

USMLE ID: _____

NBOME ID: _____

International Medical Graduates (IMGs) Only
Are you certified by the Educational Commission for Foreign Medical Graduates (**ECFMG**)? __Yes __ No

ECFMG #_____ Issue Date: _____

Birth Country: _____ Birth City: _____DOB:_____

Military Service Obligation: _____Other Service Obligations: _____

Felony Convictions: _____ Limitations: _____

EXAMINATIONS	**STATUS**	**DATE**

ACLS: **PALS:** **DEA#:** **BOARD CERTIFICATION**

STATE MEDICAL LICENSES:
TYPE: **NUMBER:** **STATE:** **EXPIRATION DATE**

Medical Licensure Problems? If yea, please explain_____

Ever named in a Malpractice Suit? If yes, please explain: _____

MEDICAL EDUCATION:
INSTITUTE & LOCATION **DATES ATTENDED** **DEGREE** **DATE OF DEGREE**

MEDICAL SCHOOL HONORS/ AWARDS:

MEMBERSHIP IN HONORARY/PROFESSIONAL SOCIETIES:

OTHER EDUCATION INSTITUTION & LOCATION DATES ATTENDED /FIELD OF STUDY /DEGREE

CURRENT/PRIOR TRAINING

PRGRAM INSTITUTION& LOCATON PROGRAM DIRECTOR DATES ATTENDED YEARS

EXPERIENCE

EXPERIENCE	ORGANIZATION & LOCATION	DATES ATTENDED	SUPERVISOR AVG HRS/WK

PUBLICATIONS:

LANGUAGES SPOKEN (OTHER THAN ENLISH)

HOBBIES & INTERESTS

OTHER AWARDS/ ACCOMPLISHMENTS

CERTIFICATION:
I certify that the information contained within my application is complete and accurate to the best of my knowledge. I understand that any false or missing information may disqualify me from consideration for a position, or if employed, may constitute cause for termination from the program. If accepted, I understand a background check will be done.

SIGNATURE: _____ DATE: _____ ATTACH PHOTO