LEE HEALTH | THE FLORIDA STATE UNIVERSITY COLLEGE OF MEDICINE

Medical Student Application			
First Name:		**Last Name:**	
Email Address:		**Phone Number:**	
Address:		**City/State/Zip:**	
Medical School Name:		**Medical School Location (city and state, or country):**	
Expected Med School Graduation Date:		**Current Medical School Year:**	
Briefly explain why you would like to rotate with our residency program:			
2-week and 4-week externship programs run year-round. Please indicate your preferred externship start dates, 2-week or 4-week program participation, and if you require housing:			
1st Choice			
Preferred Start Date:		**Program Length (2 or 4 weeks):**	
Housing Required (yes or no):			
2nd Choice			
Preferred Start Date:		**Program Length (2 or 4 weeks):**	
Housing Required (yes or no):			
3rd Choice			
Preferred Start Date:		**Program Length (2 or 4 weeks):**	
Housing Required (yes or no):			
Do you have any special needs we should know about?			

Will you be requesting any time off during the Externship? If so, please explain.
Please Read the Following Terms Carefully. Select Each Checkbox If You Agree:
☐ I hereby certify that all of the information listed on this form is true and complete. I understand that any false, incomplete or misleading information given by me on this application is sufficient cause for rejection. ☐ I also understand and agree that any false, incomplete or misleading information discovered on this application at any time after I begin the Externship Program may result in my dismissal X_____ Medical Student Signature / Date