2020 Hospital Medical Education Program Application Form

Applicant Information:

Name:

Present Address:

Phone: E-Mail Address:

Hometown: Indiana Home **County**:

Medical School:

Medical School Campus, if applicable:

Questions Pertaining to the Program:

1. What are your expectations concerning the HME Program?

2. What do you plan to do after you have completed your medical education?
(Please check the appropriate responses)

☐ A. Practice Only: ◯ Primary Care ◯ Specialty ◯ Unknown

☐ B. Research Only: ◯ Basic Science ◯ Clinical ◯ Translational

☐ C. Practice & Research: ◯ Academic ◯ Non-academic

☐ D. Other

3. Have you been involved in medical or paramedical activities outside the medical school curriculum?

☐ Yes ☐ No

If yes, Positions:

Location: Length of time:

4. Are there any special circumstances that may conflict with your participation in this program? (Example, Military Officer Training, Wedding, Vacations, etc…)

5. **Choice of Hospital(s):**

Please list in order, your preferences of the hospitals as potential positions. **Hospital Interviews and the application form are due by Monday, February 3, 2020. Check the Participating Hospital Contact List. Some hospitals may have specific preferences or requirements listed in NOTES.**

(1.) (room & board needed) **Y** ☐ **N** ☐ (interviewed w/ hospital) **Y** ☐ **N** ☐

(2.) (room & board needed) **Y** ☐ **N** ☐ (interviewed w/ hospital) **Y** ☐ **N** ☐

(3.) (room & board needed) **Y** ☐ **N** ☐ (interviewed w/ hospital) **Y** ☐ **N** ☐

6. Give a brief explanation of your preferences listed above. Why is it important that you should be at one of these three hospitals? (Please write your explanation below.)

7. If you do not match in any of the three hospitals listed, do you wish to be contacted regarding participation at another participating hospital available, which may not be in your choice area? *(You would be under no obligation to accept the assignment and would have the opportunity to decline.)*

☐ Yes ☐ No If Yes, please list alternate participating hospital(s):

8. If you have made arrangements with a participating hospital on the list or not on the list, still complete this application and make a note of the arrangement below:

Please Read Carefully:

☐ I have read carefully and agree to abide by the program goals and guidelines. I will participate in the orientation sessions for the program and complete all evaluation materials. I will notify the program and the hospital immediately in the event that I am unable to participate at the hospital to which I have been assigned. I agree to cooperate with participating hospital and the Administrator of this program in the administration and evaluation of this program.

Date:

Application Deadline Monday, February 3, 2020

Mail or fax to:

Jose Espada
1130 West Michigan Street, FH 224
Indianapolis, IN 46202-5120
Fax: (317) 278-2691
E**-mail application as an attachment to jespada@iu.edu (preferred)**

Complete PDF fillable form and save to your computer before attaching to an e-mail.