2020 Hospital Medical Education Program

**Hospital Application Form**

***Please return by Friday, November 22, 2019***

# **HOSPITAL INFORMATION:** Please print

|  |  |  |  |
| --- | --- | --- | --- |
| Hospital/Institution: |  | | |
| Address: |  | | |
| City/State: |  | Zip: |  |
| County: |  | Phone: |  |
| Fax: |  | Email: |  |

Hospital contact:

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Name: | Title: | Phone: |

SPECIAL ELIGIBILITY REQUIREMENTS FOR ASSIGNING STUDENTS TO YOUR HOSPITAL (please check all that apply):

Hospital has special requirements:  Yes  No

If yes, what are those requirements? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Students must be from Indiana:  Yes  No

Students must be from county in which hospital is located:  Yes  No

If yes, does this include surrounding counties? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Hospital requires an interview:  Yes  No

(Interview must be completed by Friday, January 31, 2020)

|  |  |
| --- | --- |
| Other: |  |

**Program specifics (Please check all that apply):**

Maximum number of students:

Hospital will provide housing:  Yes  No

Hospital will provide meals:  Yes  No

Length of Program (designate number of weeks):

Amount of Weekly Stipend: $

(Please note that offering a weekly stipend is an important and essential feature as medical students have living expenses during the summer when they are not in school and this serves as a resource to cover those expenses.)

|  |  |
| --- | --- |
| Additional Comments: |  |

**REMINDER:** Please send to: Jose Espada, 1130 West Michigan Street, Fesler Hall 224, Indianapolis, Indiana 46202, or fax to (317) 278-2691 or email to [jespada@iu.edu](mailto:jespada@iu.edu) as a PDF attachment. Our preference is to receive it as an attachment to an e-mail.

## APPLICATION DEADLINE: Friday, November 22, 2019

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Signature: |  |  | Signature: |  |
|  | (Administrator) |  |  | (Hospital Contact) |
|  |  |  |  |  |
| Name: |  |  | Name: |  |
|  | Please Print (Administrator) |  |  | Please Print (Administrator) |