



## 2019 Hospital Medical Education Program Hospital Application Form

### **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, Feb. 1, 2019)

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, 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 email.

**APPLICATION DEADLINE: Wednesday, Dec. 5, 2018**

Signature: \_\_\_\_\_  
(Administrator)

Signature: \_\_\_\_\_  
(Hospital Contact)

Name: \_\_\_\_\_  
Please Print (Administrator)

Name: \_\_\_\_\_  
Please Print (Hospital Contact)