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& LOCATION: __________________________ PROGRAM DIRECTOR: __________________________ DATES ATTENDED: __________________________ YEARS: __________________________
**EXPERIENCE**

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<th>EXPERIENCE</th>
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**PUBLICATIONS:**

**LANGUAGES SPOKEN (OTHER THAN ENGLISH)**

**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

GRiffin Hospital * 130 Division St. * Derby, CT. * 06418