

Application Form

Please fill out the form and send it back to international@mhb-fontane.de.

Based on the information we will find your best internship and will inform you about the next steps. Please check the attached list of hospital departments.

Please also send us the following documents:

- Photo
- Current CV
- Letter of interest for a clinical elective at the MHB
- Letter of recommendation from a professor of your home faculty
- Verification of health insurance
- Verification of immunization
- Photo of passport

Applicant Information

Name:	Surname:
Date of Birth:	Gender: <input type="checkbox"/> male <input type="checkbox"/> female
Address:	City:
State / Province / Region:	Country:
Email:	Passport Number:
Passport exp. Date:	

Current Affiliation

Home University:	
Address:	City:
State / Province / Region:	Country:
Student Year:	

Details of Requested Visit

From:	To:
Desired Hospital Rank from 1 to 4. 1 being your preferred preference and 4 being the least.	Ruppiner Kliniken 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> Städtisches Klinikum Brandenburg 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> Immanuel Diakonie Bernau 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> Immanuel Diakonie Rüdersdorf 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>
Desired Department The top one being your most desired choice	1. 2. 3. 4. 5.
Knowledge of German	<input type="checkbox"/> None <input type="checkbox"/> Fair <input type="checkbox"/> Very good
Do you have any medical/physical conditions that might influence your visit?	<input type="checkbox"/> Yes <input type="checkbox"/> No