MEDICAL STUDENT CLERKSHIP

Name in Full: ____________________________

Responsible Physician(s): ____________________________

Level of Education: 3\textsuperscript{rd} Year 4\textsuperscript{th} Year (circle one)

Year and Month of Expected Graduation: ____________________________

Name of Medical School: University of Washington SOM

Medical School Address: 1959 NE. Pacific St., Box 356350
Seattle, WA 98195-6350

Name of Your Dean: Paul G. Ramsey, MD

Phone # of Dean’s Office: (206) 543-7718

STATUS:

To Observe only – NO HANDS ON

\textbf{X} To be under direct supervision of his/her responsible
Physician sponsor and/or designee

SCHEDULE: Please list our complete schedule while you are
At St. Luke’s Regional Medical Center:

Clerkship in Specialty area: ____________________________

From \textbf{______} To \textbf{______}

(month/day/year) (month/day/year)

Clerkship in Specialty area: ____________________________

From \textbf{______} To \textbf{______}

(month/day/year) (month/day/year)

I hereby certify that the information I submit in this
Application is complete and correct to the best of my
knowledge and belief.

Signature of Medical Student ____________________________

Date ____________________________

Send this form to Debra Servatius, Fax (208) 381-1508

Call Debra Servatius at (208) 381-1503 to make an
appointment for orientation and to get a name badge.

For dictation access (Permission of Responsible
Physician required), call Cynthia LaChance at (208)
381-4679 to schedule orientation to the dictation
equipment and receive a temporary access code.