GroupHealth

Application for Clinical Training

SECTION I: to be completed by trainee (please type or print clearly)

Name: _____
Last First Middle Initial

_____
Social Security #*

☐ ☐
_____ _____
Date of Birth Female Male Place of Birth (City/Country)

_____ ( ) _____ ( )
Email Permanent Telephone Local Telephone/Pager

Permanent Address: _____
Street City Zip Code Country

Local Address: _____
Street City Zip Code Country

_____ _____ _____
Medical Training Institution Year in Curriculum Undergraduate School, Degree and Year

Training Type: ☐ Visiting Resident ☐ Medical Student ☐ PA Student ☐ Other: _____

Specialty Area: ☐ Fam Med ☐ Neurology ☐ OB/GYN ☐ OPHTH ☐ Pediatrics ☐ Surgery ☐ Other: _____

Preceptor: _____ Requested Time Period: _____

At the time requested, I will have completed training in the following areas: _____

_____

Areas of medical interests (include specialties): _____

Reasons for interest in Group Health: _____

Are you planning to apply to the Group Health Family Medicine Residency Program? ☐ Yes ☐ No ☐ Undecided

Expectations of Rotation: _____

Note: Your social security number is needed to authorize you access to Group Health Intranet Resources and will not be shared outside of the Group Health Information Security Department

For Internal Use

ID **Category** **Mailstop** **Admin Contact**
kimxjx3 1/17/2007

Your signature below indicates that you have provided accurate information to GH. A signed letter must be on file with GH prior to your beginning the clinical placement.

_____

Signature of trainee Date

_____

Printed name of trainee

RETURN TO:

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