

Providence St. Peter Hospital Family Medicine Residency Program  
Olympia, Washington

CLERKSHIP INFORMATION SHEET

Student's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Type of Clerkship (e.g. Family Medicine): \_\_\_\_\_

If Family Medicine clerkship, do you want:  In-patient and Out-patient experience  Out-patient experience only

What are your career plans at present? \_\_\_\_\_

Describe any ties to Olympia or Southwest Washington: \_\_\_\_\_

What family practice experience will you have participated in before rotating with us? \_\_\_\_\_

Preferred dates of clerkship: \_\_\_\_\_

School (name): \_\_\_\_\_ Year in School \_\_\_\_\_

E-Mail address: \_\_\_\_\_

Mailing address: \_\_\_\_\_ School address: \_\_\_\_\_

Phone number: \_\_\_\_\_

License plate number (of the car you will be parking on the hospital campus): \_\_\_\_\_

School contact: \_\_\_\_\_ Title: \_\_\_\_\_

Contact phone number: \_\_\_\_\_

Emergency contact name: \_\_\_\_\_ Number: \_\_\_\_\_

Student understands that housing and transportation costs are the responsibility of the student. Student agrees to provide required information prior to beginning of clerkship.

Signed \_\_\_\_\_ Date \_\_\_\_\_

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(for administrative use below this line)

Application approved: \_\_\_\_\_ Date: \_\_\_\_\_

Application received: \_\_\_\_\_ Immunization records received: \_\_\_\_\_

HDC assigned: \_\_\_\_\_ Malpractice insurance confirmed: \_\_\_\_\_

School confirmation received: \_\_\_\_\_ Confidentiality agreement received: \_\_\_\_\_

Faculty preceptor assigned: \_\_\_\_\_ Orientation completed: \_\_\_\_\_

Hospital announcement: \_\_\_\_\_ Security orientation form: \_\_\_\_\_