

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 _____

(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: _____