PROVIDENCE ST. VINCENT MEDICAL CENTER
DEPARTMENT OF MEDICINE

Application for Visiting Student Clerkship

APPLICANT INFORMATION

Full Name: ____________________ Date: __________
Last *First* *Middle* *Preferred Name*

Mailing Address: ____________________
Address *City* *State* *Zip*

Date of Birth: __________ City Born: __________ State Born: __________

Phone: ____________________ Email: __________

Emergency Contact: ____________________ Phone: __________

If you have completed a rotation with Providence previously what was your login ID?__________

REQUESTED ROTATION DATES * (Refer to website for date options)

1st Choice: __________ 2nd Choice: __________ 3rd Choice: __________

Inpatient Medicine ☐ Medical ICU (4th year only) ☐ Outpatient Clinic (4th year only) ☐

In order to increase your chances to be scheduled for a rotation, it is suggested to list 2 to 3 date choices in order of preference.

EDUCATION

Medical School: ____________________ City/State: __________

Start Date: __________ End Date: __________ Anticipated Graduation Date: __________

Year of training during this rotation: ☐ MS3 ☐ MS4

Electives and clinical 3rd year rotations completed prior to rotation at Providence St. Vincent.

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Medical School Honors/Awards: ____________________

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Plans for Residency Training (IM, FP, other): ____________________

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OTHER

Please tell us why you are interested in applying for a clerkship at Providence St. Vincent Medical Center:

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How did you hear about our program? ☐ Internet ☐ Referral ☐ Providence Employee ☐ Other ____________

ADDITIONAL INFORMATION

*Please submit the following documentation with your application.**

- ☐ Letter from Dean's office stating the following: current student in good academic standing, approval of rotation.
- ☐ Current Class Rank
- ☐ Copy of Curriculum Vitae
- ☐ Medical School Transcripts
- ☐ USMLE (or COMLEX) Transcript – (All applicants are required to have passed Step I)
  (USMLE is not required, but highly recommended, for DO students) Official or Unofficial copy accepted.
- ☐ Copy of School ID, Passport, or State Issued ID Card
- ☐ Immunization Records (MMR, Hep B, Varicella, Tetanus & TB)
- ☐ Certificate of Liability/ Malpractice Insurance
- ☐ Verification of HIPAA Training
- ☐ 10 Panel Drug Screening & Background Check

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

Applicant Signature: ______________________________ Date: ____________________

PLEASE RETURN THIS COMPLETED APPLICATION FORM TO:

Attention: Katie Atkins
Internal Medicine Residency Program
Katie.atkins@providence.org
Phone: 503-216-2230

Providence St. Vincent Medical Center
9205 SW Barnes Road, Suite 20
Portland, OR 97225
Fax: 503-216-4041

Visit our website at: www.providence.org/stvincentedu

*** INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED.**