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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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: | | | | | | | |  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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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| If you are applying for the scholarship, please describe how you would add to the diversity of our program | | | | | | | | | | | | | | | | | | | | | | | | | |
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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 Providence St. Vincent Medical Center

Internal Medicine Residency Program 9205 SW Barnes Road, Suite 20

katie.atkins@providence.org Portland, OR 97225

Phone: 503-216-2230 Fax: 503-216-4041

Visit our website at:

https://gme.providence.org/oregon/providence-st-vincent-internal-medicine-residenc/

**\* Incomplete applications will not be processed.**