|  |
| --- |
| 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?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **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. |
|  |
|  |
| Medical School Honors/Awards: |  |
|  |
| Plans for Residency Training (IM, FP, other): |  |
|  |
|  |
| 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 |
|  |
|  |
| 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.**