PROVIDENCE Health & Services

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.

_____

_____

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:

_____

_____

_____

_____

_____

_____

_____

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

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

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