St. Peter Family Medicine Residency Program

Olympia, Washington

**SUB-INTERNSHIP APPLICATION**

Preferred dates of Sub-Internship:

STUDENT INFORMATION:

Student’s Name: Date: E-mail address: Phone number: Mailing address: Emergency contact name: Phone number:

SCHOOL INFORMTAION:

|  |  |  |
| --- | --- | --- |
| School (name): |   | Year in School  |
| School contact: |   | Title:  |
| Contact’s E-mail |   | Contact’s Phone  |

ABOUT YOU:

What are your career goals?

Describe any ties to Olympia or Southwest Washington:

What family practice experience will you have participated in before rotating with us?

What inspired you to practice medicine?

What is the most memorable volunteer experience you have had and why?

What are your hobbies and interests?

What is a fun fact about you that others may not know?

PLEASE READ:

 Student understands that housing and transportation costs are the responsibility of the student.

 Student agrees to provide required information prior to beginning of clerkship.

 Any withdraw from an accepted rotation within 2 the weeks of start date will be reported to your school which could affect your Dean’s Letter.

 Please note: if offered a rotation, your onboarding will be processed through a third party company (CPNW) which has a $100 associated fee.

Signed Date