

# Student Application Form . . .

Mr.  Ms.  Mrs. \_\_\_\_\_  
First name MI Last name

Present Address \_\_\_\_\_

\_\_\_\_\_ City State ZIP

Phone Number \_\_\_\_\_ E-mail Address \_\_\_\_\_

Permanent Address \_\_\_\_\_

\_\_\_\_\_ City State ZIP

Phone Number \_\_\_\_\_

1. Social Security Number \_\_\_\_\_

2. Medical School \_\_\_\_\_

3. Undergraduate College/University \_\_\_\_\_

4. Hometown \_\_\_\_\_

5. Are you fluent in Spanish?  Yes  No

6. Will you have access to a car for transportation during the summer?  Yes  No

7. Are you willing to commute 45 minutes or more each way to a site?  Yes  No

8. Are you willing to participate on a volunteer basis if stipend funds are unavailable?  Yes  No

9. If necessary for my particular externship experience, I will provide proof I have acquired the immunizations needed (2-step TB, rubella, rubeola, hepatitis B, etc.) prior to commencing the externship.  Yes  No

10. Are you a member of any professional healthcare or student organizations?  Yes  No

Please specify (AAFP IAFP FMIG GPIT AMSA RMED, etc.) \_\_\_\_\_

11. List any exposure you have had to history-taking, physical diagnosis or pharmacology. \_\_\_\_\_

\_\_\_\_\_

12. List your top three choices of medical specialty at this point in your career. \_\_\_\_\_

\_\_\_\_\_

13. To help us match students and preceptors appropriately, please use the scale below to indicate your level of interest in observing the following areas of a primary care medical practice:

A = Strong interest      B = Average interest      C = Minimal interest      D = No interest

a. Obstetrics/Deliveries      A   B   C   D

b. Referrals to Subspecialists      A   B   C   D

c. Mid-level Providers (NPs, PAs, etc.)      A   B   C   D

d. Nursing Home and/or Hospice Care      A   B   C   D

e. Geriatrics      A   B   C   D