

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 INFORMATION:

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

Signed

Date