NATIVIDAD
MEDICAL
CENTER

FAMILY MEDICINE CLERKSHIP APPLICATION

_____

Last Name First Name Middle Initial

_____

Mailing Address City State Zip Code

(_____)_____ _____ _____

Telephone Year in School (at time of clerkship) E-mail Address

_____

Medical School

_____

Mailing Address City State Zip Code

(_____)_____

Telephone

Length of Clerkship Requested: Preferred Dates for Clerkship:

2 Weeks _____4 Weeks_____ Choice No. 1 _____ to _____

Will you need housing? _____ Choice No. 2 _____ to _____

Will you have a car? _____ Do you speak Spanish? Fluent _____ Somewhat _____ None_____

What is your interest in our clerkship? _____

_____

Do you have a connection to the Salinas area or the Central Coast? *(If no, please explain your interest in our area)*

_____

❍ ***Please attach CV and USMLE Step 1 score***

_____ _____

Date of Application *Student's Signature*

Please return application to:

Tami Robertson
Medical Education Coordinator
Natividad Medical Center
P.O. Box 81611
Salinas, CA 93912-1611
Telephone (831) 755-4383
robertsont@natividad.com

Steve Harrison, M.D, Director,
Predoctoral Medical Education

Attach Photograph