

## 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:

2 Weeks \_\_\_\_\_ 4 Weeks \_\_\_\_\_

Preferred Dates for Clerkship:

Choice No. 1 \_\_\_\_\_ to \_\_\_\_\_

Choice No. 2 \_\_\_\_\_ to \_\_\_\_\_

**Will you need housing?** Yes \_\_\_\_\_ No \_\_\_\_\_

Will you have a car? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you speak Spanish? Somewhat \_\_\_\_\_ Fluent \_\_\_\_\_ 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 the following:**

- **Photograph**
- **USMLE Step 1 Score or COMLEX 1 Score**
- **CV**

Date of Application	Student's Signature
---------------------	---------------------

Please return application to:

Natividad Family Medicine Residency Program  
1441 Constitution Blvd., Bldg. 400, 3rd Floor  
Salinas, CA 93912-1611  
Telephone (831) 755-4201  
NMC FMRES@natividad.com