Application for Family Medicine Clerkship

Thank you for your interest in the HonorHealth Scottsdale Osborn Medical Center Family Medicine Residency Program.

Your application will be reviewed and notification made beginning in April of each year.

Please fax/send to: **Robert Marlow, MD**
Clerkship Director-SHC
7301 E. 2nd St.-Suite 210
Scottsdale, AZ 85251
Phone 480-882-4890
Fax 480-882-6801

Name: _____

Mailing Address: _____

Home Phone: _____ **Cell:** _____ **E-mail:** _____

Are you a U.S. citizen or permanent resident? (We do not sponsor visas): _____

In case of emergency, person(s) to notify:

_____

_____

Requested start & ending day of clerkship:

1st Choice: _____ ☐ **Inpatient** ☐ **Outpatient**

2nd Choice: _____ ☐ **Inpatient** ☐ **Outpatient**

Education:

College: _____
Medical school: _____
Anticipated graduation date from medical school: _____
Graduate school: _____
Other formal education: _____

Have you ever had to repeat or remediate any course or rotation? _____
If yes, please explain: _____

Have you ever had to repeat a board exam? _____

If yes, please explain: _____

Board Score - Part I: _____

Board Score - Part II (if available): _____

Please provide a transcript of classes and grades to date with your application.

Please state your reason for requesting a clerkship in family medicine and why you chose our program:

_____

_____

_____

_____

_____

Future goals in medicine:

_____

_____

_____

_____

If your application is approved, you will need to provide the following:

1. A letter from the dean's office of your medical school, verifying your standing and malpractice coverage.
2. A copy of your board scores, part I and part II (if available).
3. A current transcript of classes and grades.
4. A current immunization record and proof of health insurance.
5. The name, address and title of the appropriate person within your medical school who will sign an affiliation agreement if one is needed.
6. Your school's evaluation form.

_____

_____