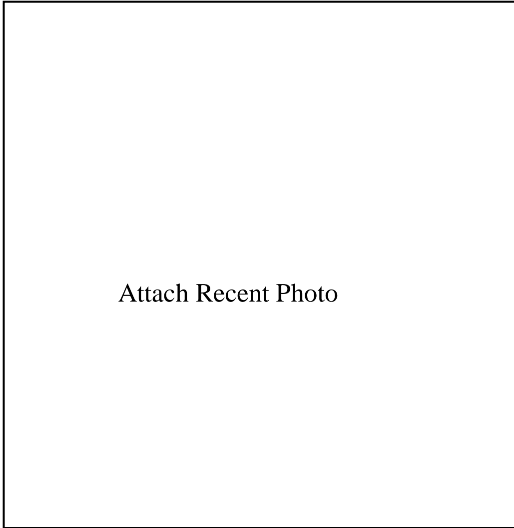
APPLICATION FOR CLINICAL OBSERVERSHIP



Academic Affairs
2213 Cherry Street
Toledo, OH 43608-2691

____
Specialty Requested

____
Requested dates of observership

Approval based on availability and not guaranteed.

PERSONAL DATA

Name		Social Security #	
Present Address	City	State/Zip	Telephone
Home Address	City	State/Zip	Telephone
Birth date	Citizenship/Country		

If you are not a United States Citizen or are not a permanent resident, be able to show proof of valid VISA status prior to start date.

____
Email Address – approval or denial will be communicated to you by email.

EDUCATION AND PROFESSIONAL DATA

____
Premedical Education (school)

Degree	Date of Graduation

____
Medical Education (school)

Degree	Date of Graduation

What are your curricular requirements:

____

____

____

____

Please attach a current, up-to-date curriculum vitae.

IMMUNIZATIONS

Hepatitis B (date) Tetanus (date) MMR (date) Polio (date)

TB screening (date) Chest x-ray (date)

Documentation of above is required.

Do you have health insurance (proof of insurance required)? ☐ Yes ☐ No

Have you received instruction regarding universal precautions? ☐ Yes ☐ No

If so, where?____

I hereby state that the above information is true and accurate to the best of my knowledge.

Applicant Signature Date

Program Director Signature of Approval Date

Chief Academic Office/Director of Medical Education Signature of Approval Date

Send this application with a $25 non-refundable application fee, in U.S. dollars, curriculum vitae, health screening documentation and proof of health insurance to:

Mercy St. Vincent Medical Center
Attn: Academic Affairs
2213 Cherry Street
Toledo, OH 43608

For Office Use Only

- ☐ Application Fee
- ☐ Health Screening Documentation
- ☐ Patient Confidentiality Agreement
- ☐ Shadow Interview/Observation Consent and Release Form
- ☐ Vitae
- ☐ Health Insurance
- ☐ HIPAA Training/Agreement
- ☐ ID Badge

Final check off prior to start date: ____
Academic Affairs Office