REQUEST FOR FAMILY MEDICINE EDUCATIONAL EXPERIENCE

Please complete and return this form by email or mail to the address above, along with:

1. Documentation of Professional Liability Insurance provided by medical school covering this educational experience.
2. Current Medical School Transcript.

Name: ___________________________ Medical School: ___________________________
Phone: __________________________ Email: ________________________________
Current Year of Training: MS1 / MS2 / MS3 / MS4

Dates of Educational Experience Requested: ________________ to ________________

How did you hear about our program? _________________________________________
________________________________________________________________________
What draws you to our program? ____________________________________________
________________________________________________________________________
Description of educational experience or purpose for making this request: ________________
________________________________________________________________________
Will you require housing? – Yes / No

Do you require any other accommodation? Yes / No ____________________________