Clinical Observership APPLICATION

Full Name: _____ DOB _____
(Last name) (First name) (MI)

Home Address:_____
(Street)

_____
(City (State) (Zip)

Phone Number:_____ Email: _____

I am applying for a clinical observership in: _____

Briefly explain your goal for this opportunity.

_____

_____

College or University: _____

Degree: _____ Date Graduated/Expected Date of Graduation:_____

Complete before sending in the following:

Sponsoring Physician: _____ Sponsoring Physicians Signature: _____

Starting Date: _____ Terminating Date: _____ (***Observer time should not exceed 8 hours***)

*** The sponsoring physician assumes the responsibilities of the observer during his/her stay. The observer shall not participate in patient care and shall not provide services or assume functions of a medical student, resident or as a member of the house staff. The hospital/facility will not be required to provide housing nor assume financial support or responsibilities. The application must be submitted a minimum of one month prior to the date of the observership request. Allow two weeks for processing. Approval will be sent once the application has been approved by leadership.

_____

Manager Medical Education
Terry Frederick

Date Approved

PLEASE RETURN THIS FORM AND ALL REQUIRED DOCUMENTS IN ONE PDF TO: MEDICAL.EDUCATION@AAH.ORG.