

### Marian Family Medicine Residency Program

Today's Date:		Database entry date:														
Student Name:																
Current Address:		Apt #:	Phone: (    )													
City, State, Zip:			E-mail:													
Emergency Contact: _____																
Relation to Applicant: _____																
Phone: _____																
Name of School:		Location:		Graduation Year _____												
Languages Spoken:																
Which programs interest you? (check all that apply) <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient  Sub-internship focusing on: <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient		Which areas of health care interest you? (check all that apply) <table style="width: 100%; border: none;"><tr><td><input type="checkbox"/> Adolescent Health</td><td><input type="checkbox"/> Health Policy/Advocacy</td><td><input type="checkbox"/> Research</td></tr><tr><td><input type="checkbox"/> Academic Health Center</td><td><input type="checkbox"/> Maternal/Child Health</td><td><input type="checkbox"/> Rural Health</td></tr><tr><td><input type="checkbox"/> Alternative Therapies</td><td><input type="checkbox"/> Osteopathy</td><td><input type="checkbox"/> Women's Health</td></tr><tr><td><input type="checkbox"/> Community Health</td><td><input type="checkbox"/> Prenatal Care / Low Risk OB</td><td><input type="checkbox"/> Other:</td></tr></table>			<input type="checkbox"/> Adolescent Health	<input type="checkbox"/> Health Policy/Advocacy	<input type="checkbox"/> Research	<input type="checkbox"/> Academic Health Center	<input type="checkbox"/> Maternal/Child Health	<input type="checkbox"/> Rural Health	<input type="checkbox"/> Alternative Therapies	<input type="checkbox"/> Osteopathy	<input type="checkbox"/> Women's Health	<input type="checkbox"/> Community Health	<input type="checkbox"/> Prenatal Care / Low Risk OB	<input type="checkbox"/> Other:
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<input type="checkbox"/> Community Health	<input type="checkbox"/> Prenatal Care / Low Risk OB	<input type="checkbox"/> Other:														
Please list top 3 choices: Month/Day/Year Requesting (Start/End): #1 _____ #2 _____ #3 _____		How did you learn about Marian Regional Medical Center? <table style="width: 100%; border: none;"><tr><td><input type="checkbox"/> Classmate</td><td><input type="checkbox"/> Colleague</td></tr><tr><td><input type="checkbox"/> School/Dean</td><td><input type="checkbox"/> Other Students</td></tr><tr><td colspan="2"><input type="checkbox"/> Publication _____</td></tr><tr><td colspan="2"><input type="checkbox"/> Other: _____</td></tr></table>			<input type="checkbox"/> Classmate	<input type="checkbox"/> Colleague	<input type="checkbox"/> School/Dean	<input type="checkbox"/> Other Students	<input type="checkbox"/> Publication _____		<input type="checkbox"/> Other: _____					
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<input type="checkbox"/> Other: _____																
Is this elective/project a requirement of your school/program?:    No    Yes																
If YES, what is the requirement: <input type="checkbox"/> Family Medicine <input type="checkbox"/> Community Medicine <input type="checkbox"/> Primary Care <input type="checkbox"/> Other: _____																
What are your future career plans?																



Are you interested in working with any special populations?	
Upon graduation, do you plan to work in a medically underserved area? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Haven't decided	Upon graduation, where would you like to work?
Have you participated in any of the Family Practice Interest Group events at your school? If so, which one(s)?	
Please include the following with this application: 1) your CV or RESUME; 2) a letter of interest which documents your reasons for wanting to rotate through our program and what you would like to accomplish during your time here; 3) USMLE/COMLEX scores; and 4) Transcript from your medical school - unofficial copy acceptable. Send completed application and supporting documents (email preferred) to:  <b>Lydia Marin</b> Extern Medical Student Program Coordinator  <b>Dignity Health</b> <b>Marian Regional Medical Center</b> 1400 E. Church Street Santa Maria, CA 93454 805.739-3369 (direct) 805.346-3505 (Fax) <a href="mailto:lydia.marin@dignityhealth.org">lydia.marin@dignityhealth.org</a>	

Reviewed by:

Faculty Member \_\_\_\_\_

Program Director/Director Medical Education \_\_\_\_\_

