# CLERKSHIP APPLICATION

______________________________________________________________________
Last Name First Name Middle Initial

______________________________________________________________________
Mailing Address City State Zip Code

(_____)____________________ ____________________ ______________________
Telephone Year in School (at time of clerkship) E-mail Address

______________________________________________________________________
Medical School Clerkship Coordinator Name and Email

______________________________________________________________________
Mailing Address City State Zip Code

(_____)____________________
Telephone

Length of Clerkship Requested: 2 Weeks _____ 4 Weeks_____

Dates of Rotation Preferred: Choice No. 1 ________________ to ________________

Choice No. 2 ________________ to ________________

Do you speak Spanish? Fluent ______ Somewhat ______ None ______

What is your interest in our clerkship? *(Please use separate sheet if more space is needed.)*

______________________________________________________________________

______________________________________________________________________

Do you have a connection to the Santa Cruz area or the Central Coast? *(Please use separate sheet if more space is needed.) If yes, please explain. If no, please explain your interest in our area.*

______________________________________________________________________

***Please attach the following:***

- ***Photograph***
- ***USMLE Step 1 Score or COMLEX 1 Score***
- ***CV***

______________________________________________________________________
Student's Signature Date of Application

*Please return application to:* Layla Franks, Undergraduate Medical Education Program Administrator
layla.franks@commonspirit.org