

**SOUTHERN COLORADO FAMILY MEDICINE RESIDENCY
CLERKSHIP APPLICATION**

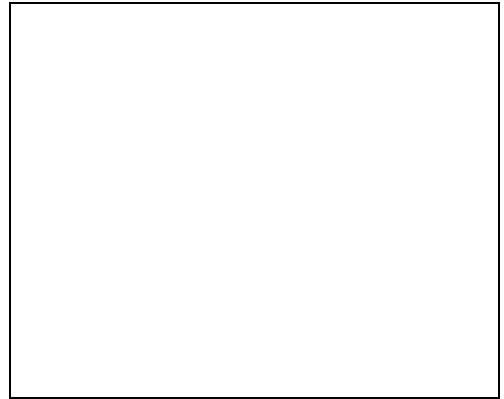
NAME: _____

D.O.B.: ____ / ____ / ____

SEX: M F

PRESENT MAILING ADDRESS:

INSERT PHOTO HERE: if available



PHONE: (____) _____ - _____

EMAIL ADDRESS: _____

DATES REQUESTED: 1. _____
Alternate: 2. _____

ROTATION REQUESTED: 1. _____
Alternate: 2. _____

MEDICAL SCHOOL:

(Name of School) (City/State)

ANTICIPATED DATE OF GRADUATION: (month) _____ (day) _____ (year) _____

FUTURE PLANS: What specialty beyond this clerkship:

Date of Application

You can use Adobe Reader to fill in this form and then print it out for forwarding to Nancy Hamilton, or you can just print out or save the blank form and fill it in later. Please note: Adobe Reader will not permit you to save the filled-in version of the form.

PLEASE EMAIL COMPLETED APPLICATION TO:

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