GroupHealth

Clinical Training Agreement

SECTION I: to be completed by trainee (please type or print clearly)

Name: _____
Last First Middle Initial

_____
Social Security #*

_____ ☐ Female ☐ Male _____
Date of Birth Place of Birth (City/Country)

_____ ( ) _____ ( ) _____
Email Permanent Telephone Cell Phone/Pager

Permanent Address: _____
Street City Zip Code Country

Local Address: _____
Street City Zip Code Country

_____ _____ _____
Current Medical Training Institution Year in Curriculum Date Program Began

_____ _____
Anticipated Completion Date Last Completed School, Degree and Year

Training Type: ☐ Visiting Resident ☐ Medical Student ☐ PA Student ☐ Other: _____

Specialty Area: ☐ Fam Med ☐ OB/GYN ☐ Pediatrics ☐ Surgery ☐ Urgent Care/Emergency ☐ Other: _____

Preceptor: _____ Time Period (Mo/Yr – Mo/Yr) _____

At the time requested, I will have completed training in the following areas: _____

_____

Areas of medical interests (include specialties): _____

Reasons for interest in Group Health: _____

Expectations of Rotation: _____

_____

Note: Your social security number is needed to authorize you access to Group Health Intranet Resources and will not be shared outside of the Information Security Department

Your signature on this letter below indicates that you have read, understood, and agreed to comply with all the above requirements of the Agreement. A signed letter with all other required documentation must be on file with GHC/GHP prior to your beginning the clinical placement. If you have any questions regarding this Agreement, please feel free to Graduate Medical Education at graduatemedicaleduca@ghc.org.

I have read the Agreement above and understand and agree to all the requirements stated.

_____
Signature of trainee Date

_____
Printed name of trainee

RETURN TO:
Graduate Medical Education
Group Health
320 Westlake Ave N, Suite 100, E2N
Seattle, WA 98109
Fax: 206-877-0649
graduatemedicaleduca@ghc.org

http://www.ghpmd.org