



FAMILY MEDICINE ROTATION APPLICATION

Name _____ Age _____ Sex _____

Birthdate (optional) _____ Land Phone () _____

Home Address _____ Cell Phone () _____

_____ Email Address _____

Name of Medical School _____

Medical School Address _____

Family Practice Department Yes _____ No _____

Chairman _____ Phone () _____

Clerkship Contact at Medical School _____ Phone () _____

TYPE OF CLERKSHIP DESIRED:

Medical Year: M3 _____ M4 _____ Month/Date/Year of Clerkship _____

Is this rotation is a _____ requirement or an _____ elective? Clerkships completed _____

Branch of medicine for career goal _____ Second choice _____

How did you hear of Floyd? _____

Do you consider Floyd a place where you might want to do a residency in family medicine?

_____ Yes _____ No _____ Unsure

Special interests / needs: _____

- * Attach resume with a personal brief statement about "Why you would like to do a Family Medicine Clerkship at Floyd in Rome."
- * Attach a copy your transcript to date and/or current GPA.
- * Upon acceptance immunization records and an affiliation agreement with your school will be needed before training. Please allow sufficient time for this.

Signature

Date

Mail application, resume with statement and transcript to:
J. LeBron McBride, PhD, MPH
Clerkship Director, Floyd Family Practice Residency Program
304 Shorter Ave., Suite 201
Rome, GA 30165
Phone 706.509.3343 Fax 706.509.4710
lmcbride@floyd.org

