University of Wyoming Family Medicine Residency Program at Cheyenne
821 East 18th Street • Cheyenne, WY 82001
(307) 777-7911 • fax (307) 638-3616
e-mail: uwcheyfm@uwyo.edu • www.uwyo.edu/chyfammed

Application for Clinical Clerkship

Name: _____

Requested Dates for Clerkship: From: _____ To: _____

Present Mailing Address: _____

_____

Telephone Number: (_____) _____ SSN: _____

Email: _____

Undergraduate School: _____

Dates: _____ Major/Degree: _____

Graduate School: _____

Dates: _____ Major/Degree: _____

Medical School: _____

Year of Graduation: _____

To be completed by Dean of Students (or comparable official) of Medical School

The Medical Student named above is in good standing at this institution and has approval to take the clerkship. Malpractice insurance DOES cover the student away from this school. Personal health coverage IS in effect away from this school. At the conclusion of the experience, a report (WILL) (WILL NOT) be required. (If a form is used, please attach a copy.)

Signature: _____ Date: _____

Name and Title: _____

I agree to serve as a clinical clerk under the University of Wyoming Family Medicine Residency Program at Cheyenne. Should my plans change prohibiting me from serving this clerkship, I will take the responsibility to inform the Program Director immediately. I also understand that malpractice insurance is not provided by the Family Medicine Residency Program and is my responsibility.

Signature: _____ Date: _____

Notice to Student: Before your clerkship will be confirmed, the following must be on file in our office:

- A written statement that outlines your reasons for requesting this clinical experience and includes yourlong-range plans.
- A copy of your transcript.
- A listing of the clinical rotations completed and scheduled prior to clerkship.
- A copy of your STEP I score.
- Proof of COVID19 vaccine.