



*Carle Foundation Family Medicine Residency
602 West University Avenue
South Clinic 2, Urbana, IL 61801-2594*

Thank you for your interest in a clerkship with the Carle Foundation Family Medicine Residency Program. We offer clerkships for both allopathic and osteopathic medical students.

We receive more requests for clerkships than we are able to accommodate. Therefore, we must limit our clerkships to those students who express an interest in Family Medicine as a possible career choice.

Before we can accept you as a clerkship student, we ask that you complete this student information form outlining your residency plans, previous clinical experiences, and goals for this clerkship.

After reviewing your clerkship application, our faculty will determine if there is a good match between your needs and our resources.

Again, thank you for your interest in our program!

Sincerely,

Bharat Gopal, MD
Carle Foundation Hospital
Family Medicine Residency Program
Program Director

Timothy Meneely, DO
Carle Foundation Hospital
Family Medicine Residency Program
Osteopathic Program Director



**Carle Foundation Hospital
Family Medicine Residency Program
Allopathic or Osteopathic Student Clerkship Application Form**

Section 1. Demographics.

Student Name: _____

Year in School: _____

Type of Educational Experience Requested: (check one)

- Pre-clinical observership
- Required Family Medicine clerkship
- Family Medicine Elective
- 4th year Family Medicine inpatient subinternship
- Other (please describe) _____

Student Home Address: _____

Phone Number: _____

Email Address: _____

Name of School: _____
(LCME or AOA-accredited)

School Contact information:
Clerkship Coordinator: _____
Contact Email: _____
Contact Phone: _____
Contact Fax: _____

Why are you choosing to do a Family Medicine clerkship at Carle?

Section 2. Potential Residency Plans.

Please write a short statement indicating your residency plans after completing your undergraduate education. If have not yet decided on a specialty, please indicate that as well.

Section 3. Previous Clinical Experience. ¹

To help your preceptor improve your clinical skills, please indicate your current level of experience by checking the appropriate box for each item.

Physical Examination	No Experience	Some Experience	Much Experience
Gynecology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Well-child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adolescent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Complete Adult	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
System-focus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pelvic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rectal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prostate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteopathic manipulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please check if you want more instruction/experience in each of the following areas:

Procedures	
EKG Interpretation	<input type="checkbox"/>
Joint aspiration/injection	<input type="checkbox"/>
KOH (skin)	<input type="checkbox"/>
Soft tissue trigger injections	<input type="checkbox"/>
Pap smear	<input type="checkbox"/>
Testing stool for blood	<input type="checkbox"/>
Throat culture	<input type="checkbox"/>
Urinalysis (dip stick)	<input type="checkbox"/>
Wet mount/vaginal	<input type="checkbox"/>
Skin biopsy	<input type="checkbox"/>

Please indicate additional areas where you need further instruction.

¹ Adapted from Alguire, O. (2001) *Teaching in your office*. Philadelphia:ACP-ASIM.

Section 4. Goals for this Clerkship.

List the three most important goals you have for this clerkship.

- 1.
- 2.
- 3.

When you have completed the application, please return by mail, fax, or email to:

Star Andrews
Family Medicine Residency Program
611 W. Park
Urbana IL 61801
217-383-4846 (phone)
217-383-1300 (fax)
star.andrews@carle.com (email)

We need to have the completed form **60 days** prior to the start date of you intended clerkship to identify appropriate resources and ensure that the required forms are completed.

Thank you for your interest in Carle Foundation Hospital!