

Standardized Patient Recruitment Application

Please complete the following information. Details regarding your ethnic background, date of birth, height, and weight are used only to match SPs to available cases & are voluntary.

Contact information

First Name	Last Name	Street Address		
City	State	Zip Code	Phone Number	Email address
Emergency Contact Name	Relationship	Phone number	Birth date _____	
			Month	date year

Place a check mark next to all options that apply to you.

Availability:

Monday	Tuesday	Wednesday	Thursday	Friday
<input type="checkbox"/> 7:30am-12:30pm	<input type="checkbox"/> 7:30am-12:30pm	<input type="checkbox"/> 7:30am-12:30pm	<input type="checkbox"/> 7:30am-12:30pm	<input type="checkbox"/> 7:30am-12:30pm
<input type="checkbox"/> 12:30pm-5:00pm	<input type="checkbox"/> 12:30pm-5:00pm	<input type="checkbox"/> 12:30pm-5:00pm	<input type="checkbox"/> 12:30pm-5:00pm	<input type="checkbox"/> 12:30pm-5:00pm

Are you currently employed/ attending school?

Full time Part-time Self-employed Retired

Languages spoken besides English

Applicant Information

How did you hear about the program? Please give name of contact if applicable.

Have you worked as an SP? If so, tell us about your experience and please give name of contact.

Do you have experience in any of the following?

<input type="checkbox"/> Acting	<input type="checkbox"/> Classes or coursework related to health care	<input type="checkbox"/> Mentoring Students (please specify below)
<input type="checkbox"/> Former Standardized Patient	<input type="checkbox"/> Been a personal caregiver	<input type="checkbox"/> Other (please specify below)
<input type="checkbox"/> Teaching/Tutoring	<input type="checkbox"/> Professional certificate or training (please specify below)	<input type="checkbox"/> None
<input type="checkbox"/> Healthcare/Medical field		

Please provide any additional information related to your experience here:

Briefly describe your past experiences with, and opinions of physicians and other medical providers

How would you rate your comfort level on a computer?

Not at all comfortable somewhat comfortable very comfortable

Do you see yourself as articulate and would you be able to provide written and/or oral feedback to medical students in a positive, sensitive, constructive, and helpful manner? Yes No

Height _____ Weight _____ Gender _____ Ethnicity _____

Do you have any scars? If yes, please describe scar and location: (**ONLY** those that would be noticeable to students during an examination. – i.e. knee surgery scars, major abdominal or chest scars.)

Place a check next to any of the following physical conditions you have/had

- | | | |
|---|---|--|
| <input type="checkbox"/> Abnormal heart sounds | <input type="checkbox"/> Abnormal lung sounds | <input type="checkbox"/> Abnormality of the retina/eye disease |
| <input type="checkbox"/> Joint damage | <input type="checkbox"/> Abnormal thyroid | <input type="checkbox"/> Abnormal blood vessels |
| <input type="checkbox"/> Easily heard murmur | <input type="checkbox"/> Nerve damage | <input type="checkbox"/> Muscle weakness |
| <input type="checkbox"/> Other (Please describe down below) | | |

References

Company Name

Employer Name

Street address

City

State

Zip Code

Phone number

Position title and job duties

Company Name:

Employer Name:

Street address:

City

State

Zip Code

Phone number

Position title and job duties

Signature

Date