Education Application

Full Name: _____ **Date of Birth:** _____

Phone: _____ **Email:** _____ **Last 4 of SSN:** _____

Institution/School You Attend: _____

Are you currently seeking a postsecondary degree?

- ☐ Yes (Specify Degree/Major: _____)
- ☐ No

Type of Education Shadowing Requested:

- ☐ Physician Medical Student Rotation
- ☐ Graduate/Professional Program Rotation (Physician Assistant, Nurse Practitioner, Physical/Occupational Therapist, Nurse, Extern)
- ☐ General Job Shadow
- ☐ Other: _____

If you have a preference on which OAM physician, provider, and/or specialty you are assigned to, please list here: _____

OAM Location(s) Requested *(please check all that apply)*:

- ☐ OAM Clinical Office(s)
- ☐ OAM Surgery Center

Observation/Shadow Date(s) Requested: _____

Emergency Contact Information:

Name: _____

Phone Number: _____ **Relationship:** _____

- ☐ *I understand that should I need medical attention during or as a result of this clinical experience, I assume full responsibility for any treatments and associated medical costs deemed necessary. I release Orthopaedic Associates of Michigan from all liability.*
- ☐ *I understand that all healthcare information, patient care and records are a confidential matter. I agree that all information exchanged while I am observing will be held in strictest confidence.*

Signature: _____ **Date:** _____