



**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  
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