## CENTRAL WASHINGTON FAMILY MEDICINE
## ELECTIVE FOUR-WEEK SUB-INTERNSHIP APPLICATION

Student Name: ______ Street Address: ______

City: ______ State: ______

Zip Code: ______ Email: ______

Home Phone: ______ Cell Phone: ______

Medical School: ______ Current Year in School: ______

**Preferred Sub-internship Date:**

| First Choice | | Second Choice | |
|---|---|---|---|
| Begin: | | Begin: | |
| End: | | End: | |

Tell us about your interest in Family Medicine:

List the Learning Objectives for your sub-internship:

Do you have family or other ties to the Yakima area?
Yes ☐ No ☐

Do you need a place to stay during your sub-internship?
Yes ☐ No ☐

Are you applying for residency here?
Yes ☐ No ☐

If yes, would you like to interview during your sub-internship?
Yes ☐ No ☐

Send Clear