

# AACPM 2006 Uniform Podiatric Clerkship Application

Name of Program: \_\_\_\_\_

Applicant Name: \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
Street Apt #

\_\_\_\_\_ City State Zip

Permanent Address: \_\_\_\_\_  
Street Apt #

\_\_\_\_\_ City State Zip

Telephone Number: (\_\_\_\_) \_\_\_\_\_ Email (opt) \_\_\_\_\_

**In Case of Emergency, Please contact:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_

Citizenship: \_\_\_\_\_

Podiatric College: \_\_\_BUSGMS \_\_\_OCPM \_\_\_CSPM \_\_\_SCPM \_\_\_CPMS \_\_\_TUSPM NYCPCP

Graduation Year: \_\_\_\_\_ Have you passed Part I Boards? \_\_\_YES \_\_\_NO \_\_\_NOT TAKEN

Preferred Month of Rotation: 1<sup>st</sup> choice \_\_\_\_\_

2<sup>nd</sup> choice \_\_\_\_\_

3<sup>rd</sup> choice \_\_\_\_\_

**Colleges/Universities you have attended:**

Name: \_\_\_\_\_ Degree: \_\_\_\_\_

Name: \_\_\_\_\_ Degree: \_\_\_\_\_

Name: \_\_\_\_\_ Degree: \_\_\_\_\_

**Previous Health Care Professional Schools**

Name: \_\_\_\_\_ Degree: \_\_\_\_\_

Name: \_\_\_\_\_ Degree: \_\_\_\_\_

**Papers you have Authored/Co-authored:**

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**Research in progress:**

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**Ranked academically as # \_\_\_\_\_ out of \_\_\_\_\_ students in the class**

**Activities you have participated in during Podiatry school**

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**Honors you have received while in professional school; scholarship, honor societies, etc.**

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**References**

1. Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: (\_\_\_\_\_) \_\_\_\_\_

2. Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: (\_\_\_\_\_) \_\_\_\_\_

**Please attach photo here (if required):**

**\*\*Please send this completed application to the program you named above. Additional information required may be sent along with this application. Check with the Clerkship Director at your school and the current Clerkship Handbook for the specific requirements of this program.**