KAISER PERMANENTE®
WASHINGTON PERMANENTE MEDICAL GROUP

Clinical Training Agreement

SECTION I: to be completed by trainee (please type or print clearly)

Name: _____
Last First Middle Initial

_____
Social Security #*

_____ ☐ ☐ _____
Date of Birth Female Male Place of Birth (City/Country)

_____ ( ) _____ ( ) _____
Email Permanent Telephone Cell Phone/Pager

Permanent Address: _____
Street City Zip Code Country

Local Address: _____
Street City Zip Code Country

_____ _____ _____
Current Medical Training Institution Year in Curriculum Date Program Began

_____ _____
Anticipated Completion Date Last Completed School, Degree and Year

Training Type: ☐ Visiting Resident ☐ Medical Student ☐ PA Student ☐ Fellow ☐ Other: _____

Specialty Area: ☐ Fam Med ☐ OB/GYN ☐ Pediatric ☐ Surgery ☐ Urgent Care/ Emergency ☐ Other: _____

Preceptor _____ Time Period (Mo/Day/Yr – Mo/Day/Year) _____
(Clinician's Name – Rotating With)

At the time requested, I will have completed training in the following areas: _____

_____

Areas of medical interests (include specialties): _____

Reasons for interest in Kaiser Permanente: _____

Expectations of Rotation: _____

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Application for Clinical Training

Note: Your social security number is needed to authorize you access to Kaiser Permanente Health Plan of Washington Intranet Resources and will not be shared outside of the Information Security Department

Your signature on this letter below indicates that you have read, understood, and agreed to comply with all the above requirements of the Agreement. A signed letter with all other required documentation must be on file with Kaiser Permanente Health Plan of Washington/Kaiser Permanente Washington Permanente Medical Group prior to the start date of your clinical placement. If you have any questions regarding this Agreement, please feel free to email Graduate Medical Education at: graduatemedicaleduca@ghc.org.

I have read the Agreement above and understand and agree to all the requirements stated.

_____
Signature of trainee Date

_____
Printed name of trainee

RETURN TO:
Graduate Medical Education
Washington Permanente Medical Group
Via Email: graduatemedicaleduca@ghc.org

Kaiser Permanente Health Plan of Washington
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Seattle, WA 98109
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