

**CLINICAL SKILLS PROGRAM**

**STANDARDIZED PATIENT APPLICATION**

**Contact and General Information:**

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| --- | --- |
| FIRST NAME: | LAST NAME: |
| STAGE NAME (if different from above): | |
| ADDRESS: | CITY, STATE, ZIP CODE: |
| PRIMARY PHONE: | SECONDARY PHONE: |
| EMAIL: | BEST TIME AND WAY TO REACH YOU: |
| Are you on Emory’s payroll or have you been on their payroll within the year?  (If yes, please briefly explain.) | |
| How did you hear about Emory’s Standardized Patient program? | |
| Are you usually available Monday- Friday between 7:30am and 5:30pm? If no, please explain. | |

**Personal Profile:**

|  |
| --- |
| Briefly describe yourself. |
| *This information is solely intended to determine suitability for certain roles.*  Do you have any scars, irregularities, or special medical conditions that might enhance or impede your ability to portray specific roles? |
| Describe any previous experience as a Standardized Patient (roles trained for, where worked, etc.). |
| Please list any other information you feel would be of use to us (occupations or professions you can discuss intelligently, experience in providing feedback, teaching experience, evaluation experiences, etc.). |

**The following information is used for casting purposes only:**

|  |  |
| --- | --- |
| DATE OF BIRTH: |  |
| HEIGHT: | WEIGHT: |

**Employment Information:**

**Please list current employer below:**

|  |  |
| --- | --- |
| Employer: | Full- time Part-time |
| Supervisor: | Job Title: |
| Phone number:  \* May we contact your supervisor? Yes No | Job Duties: |

**In the space below please provide *two (2) references; one (1) professional and one (1) personal*.**

|  |  |
| --- | --- |
| Name: | Name: |
| Phone number: | Phone number: |
| Relationship: | Relationship: |

|  |  |
| --- | --- |
| Signature | Date |

**Thank you for your interest in being a Standardized Patient for Emory University.**

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