Clinical Observation Application

(to be completed by applicant)

Name _____

Mailing Address _____

Current Employer _____

Employer Address _____

Country of Citizenship _____

Country of Permanent Residency _____

Sponsoring Southwestern Physician _____

Sponsoring Southwestern Department _____

Certification/Licensure (*List all that you hold at this time*)

Type _____ **Date Granted** _____ **Granting Agency** _____

Type _____ **Date Granted** _____ **Granting Agency** _____

Anticipated dates of clinical observation (Must not exceed a total maximum of 90 days)

From _____ **To** _____

Specific activities you plan to participate in while at UT Southwestern:

_____

_____

Your goals and objectives for participating in this observation program:

_____

_____

I confirm that I have read the clinical observation policy (copy attached) and I agree to comply with all aspects of this policy. I certify that the information in this application is complete and correct to the best of my knowledge.

_____ _____

Signature **Date**

I release from liability and from any restrictions as to confidentiality or privacy all hospitals, schools, physicians, employers, individuals, agencies or organizations that provide information about me at the request of The University of Texas Southwestern Medical Center at Dallas.

_____ _____

Signature **Date**

Last updated: March 28, 2011