

**EXTERNSHIP APPLICATION**  
**FAMILY MEDICINE RESIDENCY PROGRAM**  
**HALIFAX MEDICAL CENTER**

**Full Name:** \_\_\_\_\_  
(First) (Middle) (Last)

**Home Address:** \_\_\_\_\_  
\_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**Medical School:** \_\_\_\_\_

**School Address:** \_\_\_\_\_  
\_\_\_\_\_

**Expected Graduation Date:** \_\_\_\_\_ **E-mail:** \_\_\_\_\_

**How Did You Hear About This Program?** \_\_\_\_\_

**List Preference for Dates of Externship:**

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

**Will You Require Housing During Your Stay?**  Yes  No

**Please include the following with your application:** Copy of USMLE board score(s), copy of medical school transcript, and letter of "good standing" from Dean of Medical School with verification of malpractice insurance coverage.

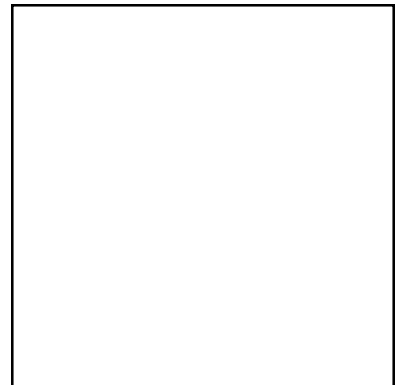
**NOTE:** An agreement between the Medical School and Halifax Medical Center must be in place prior to the starting date of the rotation. Please provide a contact name and phone number at your school:

\_\_\_\_\_  
Signature Date

**Please send all data to:**

Edwin E. Prevatte, M.D., Director  
Family Medicine Residency Program  
Halifax Medical Center  
P.O. Box 2830  
Daytona Beach, FL 32120-2830

E-Mail Address:  
residency.coordinator@halifax.org



*Photo (Optional)*