FAMILY MEDICINE CLERKSHIP REQUEST FORM
NAVAL MEDICAL CENTER CAMP LEJEUNE

Last Name: First Name: Middle Initial:

E-Mail Address: Cell Phone Number:

Branch of Service: Rank: DOD ID:

CAC or Reservist ID expiration date (month/day/year):

Date of Birth:

Name and address of medical school:

Year you will be at the time of the clerkship: ☐ 3rd ☐ 4th

Are you : ☐ USUHS ☐ HPSP

If HPSP, are you coming on: ☐ AT Orders ☐ Civilian

If coming as a civilian, a Training Affiliation Agreement (TAA) is required from your school. Please provide TAA point of contact name, email and phone number:

Preferred clerkship dates (month/day/year): Clerkship Type: FM ☐ SUB-I ☐

From: To:

Alternate clerkship dates (optional):

From: To:

Are you interested in interviewing? ☐ Yes ☐ No

Emergency POC: Phone Number: Relationship:

Additional Comments:

Please return form to:
usn.lejeune.navmedcenclnc.list.nmccl-fmc-gme-coordinator@health.mil