Marshfield Clinic
Health System

Educational Opportunities Application

We must have this form back in the Division of Education a minimum of 30 business days prior to your experience.

Name (print) _____
First name Middle initial Last name

Address _____

City _____ State _____ ZIP _____ Country _____

Home phone (_____) _____ Cell phone (_____) _____

Date of birth ____/____/____ E-mail address _____

School Information

School _____ Program _____

School address _____

City _____ State _____ ZIP _____ Country _____

School contact _____ Phone _____

E-mail address _____

Rotation Requesting

Department requesting _____ Dates _____

Center _____

Department requesting _____ Dates _____

Center _____

Department requesting _____ Dates _____

Center _____

Residency Information (If Applicable)

Are you interested in applying to the Marshfield Clinic Health Systems Residency Program:

☐ Yes ☐ No ☐ Not sure

If yes, what programs: ☐ Dermatology ☐ Pediatrics ☐ Internal Medicine/Pediatrics
☐ Internal Medicine ☐ General Surgery ☐ Transitional Year

Division of Education Contact Information

Questions, call 1-800-541-2895. Forward the completed report and any additional information using one of the following routes:

Fax information to 715-847-3811 **Email information to studentprograms@marshfieldclinic.org**

