Marshfield Clinic®

Observational Experience Application

Name (print) ____
First name   Middle initial   Last name

Address ____

City ________________ State ________ ZIP ____________ Country ________________

Home phone (_______) ____________________ Cell phone (_______) ____________________

Date of birth ______ /______ /______ E-mail address ____________________________

School name ______________________________ Current year in school ____________

Course name (if applicable) ____

What do you expect to gain from this experience ____

____

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____

What are your future career plans ____

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____

Do you have any healthcare experience such as volunteer work and/or employment: ☐ Yes ☐ No

If yes, what ____

____

Are you requesting this experience to meet a prerequisite: ☐ Yes ☐ No

If yes, provide documentation (i.e. page from a website) ____

____

Why Marshfield Clinic ____

____

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Information about requested experience

Have you made contact with a person/department: ☐ Yes ☐ No If yes, who ____________________

Date(s) requesting/available ____

First choice ____________________ Second choice ____________________ Third choice ____________________

Center/Clinic location ____

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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**

Mail information to: **Central District** – Student Programs – 2R6, 1000 North Oak Avenue, Marshfield, WI 54449
East District – Student Programs – W2E, 2727 Plaza Drive, Wausau, WI 54401
North District – Student Programs, P.O. Box 1390, Minocqua, WI 54548
Northwest District – Student Programs, 1700 West Stout Street, Rice Lake, WI 54868
West District – Student Programs, 2116 Craig Road, Eau Claire, WI 54701

For Office Use Only

Date(s) of Experience	Department	Physician/Staff

Approved by ____ Date _____ /_____ /_____

Comments ____

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