RUTGERS
New Jersey Medical School

# The Clinical Skills Center
# Standardized Patient Application Form

*Please forward a completed application form together with your most recent photo to:*
*The Clinical Skills Center @ New Jersey Medical School*
*30 Bergen St. ADMC Building 9 Room 901 Newark, NJ 07107*

**First Name**: _____ **Middle Initial**: _____ **Last Name**: _____

Date of Birth: _____ Age: _____ Gender: ___ Male___ Female

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Work Phone: _____ Fax No.: _____

Cell Phone: _____

Pager: _____

Email Address: _____

Occupation: _____

Employer/Company Name: _____

Work Address: _____

City: _____ State: _____ Zip: _____

Highest level of education or training:

__ High School
__ Technical School
__ Some college
__ College degree
__ Post graduate degree
__ Other: (Pls. specify) _____

**IN CASE OF EMERGENCY PLEASE CONTACT**: _____

Address: _____

(Street) (City) (State) (Zip)

Phone number: _____

Relationship to applicant: _____

***All Information is Confidential.***

Do you have training or experience in the health or medical field? __ Yes __ No

Are you familiar with medical terminology? __ Yes __ No

How did you hear about our Standardized Patient Program? _____
_____
_____

Have you ever worked as a Standardized Patient: ____ Yes ____ No

Please check all that apply: (Experience)

__ Small group portrayals with 8-10 students and 1-2 faculties
__ Video-taped (Standardized Patient) SP portrayals
__ History taking
__ Sharing a personal medical experience
__ Health Counseling and teaching
__ Upper body physical examination
__ Lower body physical examination
__ Other: (Please specify) _____

Are you willing to allow trainees to perform non-invasive physical exam? __ Yes __ No

Are you willing to be part of a female (breast or GYN)/Male (GU) exam? __ Yes __ No

Would you be interested in learning more about being a simulated patient for upper and lower body physical examination?(Check One) ___ Yes __ No

When are you available? (Indicate all that apply.)

__ Weekday morning
__ Weekday afternoon
__ Weekday evening
__ Weekends

Are you available all year round? __ Yes __ No

Best time to call: ___Day ___ Evening (after 5:00 pm)

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Ethnic background:

___ African American ___ Alaskan Native ___ Caucasian
___ American Indian ___ Asian
___ Pacific Islander ___ Hispanic or Latino
___ Other: [Provide brief description] _____
_____

Primary language(s) spoken: _____

Other language(s) spoken: _____

Fluency (Circle One): 1 (Very Fluent) 2 3 4 5 (Not fluent)

1. Please provide a brief description of yourself including height, weight, and physical characteristics:
_____
_____
_____
_____

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2. What special skills/abilities/experiences do you bring to the role of Standardized patient: _____
_____
_____

2a. Describe your experience, including roles you have portrayed at NJMS: _____
_____
_____
_____
_____
_____

2b. Describe your experience at other institutions: _____
_____
_____
_____
_____
_____

3. List any distinguishing physical features such as scars, birthmarks, tattoos and specify where they are located: _____
_____
_____

4. Please list any current medical conditions: _____
_____

5. Please list any physical limitations you may have: _____
_____

6. Please list any surgeries you have had (include the year): _____
_____

7. Do you have any teaching experience in any context? __ Yes __ No
If yes, please specify: _____

8. Do you have any additional skills, knowledge or experience that you think might be helpful to our program? Is there any other information you would like to give that might be helpful (health habits, family, lifestyle, etc)?
_____
_____

*I certify that all of the information furnished in this application is true and complete to the best of my knowledge. I understand that the university may investigate the information I have furnished. I authorize any person, firm or organization to supply any information concerning any past employment, military status, convictions, or other information to the University of Medicine and Dentistry of New Jersey - New Jersey Medical School.*

_____ _____
Signature Date

***All Information is Confidential.***