



**Robert C. Byrd Health Sciences Center – Eastern Division  
Standardized Patient Application**

Salutation (Mr., Ms., Mrs., Dr., etc) \_\_\_\_\_

Full Name \_\_\_\_\_

Telephone # Home# \_\_\_\_\_ Cell # \_\_\_\_\_

Work # \_\_\_\_\_

E-mail Address \_\_\_\_\_

Home Street Address \_\_\_\_\_

City \_\_\_\_\_ ST \_\_\_\_\_

Zip \_\_\_\_\_ County \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Race/Ethnic Background (optional) \_\_\_\_\_

Marital Status \_\_\_\_\_ Number of Children \_\_\_\_\_

Please provide a brief summary of your work history \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Note: All information on this form is confidential and will be used for the purpose of the application and payment process for the Patients as Educators Program through West Virginia University Robert C. Byrd Health Sciences Center. I understand that the University may investigate the information I have furnished. I authorize any person, firm or organization to supply any information about me concerning any past employment, military status, convictions, or other information to West Virginia University Robert C. Byrd Health Sciences Center and I further release any such person, firm or organization from any responsibility in disclosing such information including from all liability for any damage that may result from furnishing such information to the University. West Virginia University is a drug-free workplace. Your signature below verifies all information provided on this form is true and correct.

Please email this form to: [CTaylor@hsc.wvu.edu](mailto:CTaylor@hsc.wvu.edu) or Fax to: 304-264-9042 Attn: Cindy Taylor

Or please mail this completed form to:

West Virginia University  
Robert C. Byrd Health Sciences Center  
Attn: Student Services  
2500 Foundation Way  
Martinsburg, WV 25401

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Social Security # (for compensation purposes) \_\_\_\_\_

For more information on the program please contact (304) 264-9202.