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

Full Name_____

Telephone Home #_____ Cell # _____

Work #_____

E-mail Address _____

Home Street Address_____

City_____ State _____

Zip Code_____ 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 all liability from any damage that may result from furnishing such information to the University. West Virginia University is a drug-free workplace. Your signature below verifies that all information provided on this form is true and correct.

Please email this form to: horstj@wvuh.com or Fax to: 304-596-6330 Attn: Jane Horst

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: _____

For more information on the program, please contact (304) 264-9202 Option 1