

Standardized Patient Application

Please Print Legibly.

Name: _____

Street Address: _____ Apt. #: _____

City: _____ State: _____ Zip code: _____

Cell phone #: _____ Home phone #: _____

Work phone #: _____ Fax: _____

Email: _____

Date of Birth: _____

*Height: _____ *Weight: _____ Hair Color: _____ Eye Color: _____

**Ethnicity/culture: _____

** Most patient cases are type specific. Knowledge of your body type will help in casting for various cases.*

*** We ask for race information because some of our projects are about cultural competency. If you are a member of a particular culture or race, there is a possibility that you could be hired for such projects.*

How did you learn about our program?

- Magazine article TV Radio Internet
 Newspaper article Classifieds Word of Mouth

If you checked "Word of Mouth", please tell us the name of that person, your relationship, and their phone #, if possible.

Explain: _____

Educational Background

Education level (Check all that apply): BA BS MA MS MFA PhD Other: _____

From what University did you get your degree? _____

What is your degree or specialty in? _____

Do you have a background in either education or medicine? YES NO

If "YES", please explain: _____

Standardized Patient Background

Have you ever worked as a Standardized Patient before? YES NO

If "YES", where? (Please include name of program and which University affiliation, if any.): _____

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Name and phone # of SP Trainer/Director: _____

What case(s) or conditions did you portray?

Cases/Condition

Medical History

We often hire people who have real medical findings or conditions. Please be as detailed as you feel comfortable with when answering the following questions.

Do you have any current illnesses (asthma, diabetes, heart murmur, etc.)? YES NO

If YES, please explain:

If you have any real or interesting physical findings, please explain:

Please list any scars or physical markings (birthmarks, tattoos, piercings, etc.):

Scars: _____

Birthmarks: _____

Tattoos: _____

Piercings: _____

Other: _____

Please list any medications/supplements you take on a regular basis:

Please list any allergies or other conditions that we might need to know about:

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Employment History

Are you currently employed?

YES NO Part Time Full Time Retired Self-employed

Name of employer (current or most recent): _____

Supervisor's name and phone number: _____

What type of work do you do at this company? _____

Dates of employment (including year/s): Beginning: _____ Ending: _____

If you are no longer working there, please state your reason for leaving:

Please list any specific days of the week and times that you will be unavailable to work for us:

References

Please list three references that we may contact (2 professional & 1 personal):

Name	Phone Number	Relationship
1.) _____	_____	_____
2.) _____	_____	_____
3.) _____	_____	_____

Please eMail this application, along with a cover letter, headshot (or recent photo),
and your resume (theatrical and/or professional) to crose@uic.edu.
You may also fax it to the **attention of Chris Rose, Center Manager** at (312) 996-6365

Please feel free to follow up with a hardcopy of your resumes and headshots, to the address below:

UIC Clinical Performance Center
Dept. of Medical Education (MC 591)
808 South Wood St., Rm. 986 CME
Chicago, IL 60612