Stanford HEALTH CARE
STANFORD MEDICINE

Stanford Health Care/Lucile Packard Children's Hospital at Stanford
Visiting Residents Information Form

Stanford department/division name: ______________________________

Elective dates: ______________________ ______________________
Start Date End Date

Visiting Resident's Information:

Name: ____
Last First Middle

______________________ ______________________
Social Security number Birth date

______________________ ______________________
Email address Cell phone number

In emergency notify: ______________________________________
Contact name Relationship

____
Contact phone number

______________________ ______________________
Medical License number Expiration date

______________________ ______________________
Medical school name Location

Graduation date (month/year):

Complete Training History:
Pls. include current academic year

PGY	Specialty	Training site name & location	Dates
I			
II			
III			
IV			
V			
VI			
VII			

______________________ ______________________
VR Signature Today's date