Print Form

Your Name: _____ Date: _____

Phone: _____ Email: _____

Are you a recent graduate? Yes ☐ No ☐

Did you do any portion of your training at the West LA VA Medical Center? Yes ☐ No ☐

Geographic Location: Please indicate your preference, with number one (1) being your first choice, two (2) your second choice, etc.:

_____ West Los Angeles VA Medical Center (WLA)
_____ Los Angeles Ambulatory Care Center (LAACC)
_____ Sepulveda Ambulatory Care Center (SACC)
_____ Santa Barbara Community-Based Outpatient Clinic (includes San Luis Obispo & Santa Maria Community-Based Outpatient Clinics)
_____ Bakersfield Community-Based Outpatient Clinic (BACC)

Area of Specialty: Please indicate your preference, with number one (1) being your first choice, two (2) your second choice, etc.:

_____ Medical / Surgical
_____ Operating Room
_____ Geriatrics / Rehabilitation
_____ Home-Based Primary Care
_____ Critical Care
_____ Ambulatory / Primary Care
_____ Community Care
_____ Mental Health

_____ Other (please specify): _____

Referral Source (please select all that apply to how you were referred to us):

☐ Friend ☐ VA Employee ☐ Newspaper Ad ☐ Job Fair

☐ Conference ☐ Magazine Ad ☐ Internet Site

Other (please specify): _____