Memorial

GRADUATE MEDICAL EDUCATION

RESIDENT COMMUNITY OUTREACH EVENT REQUEST

Name of the Event:

Date of the Event:

Start time and duration of event:

Location of the Event:

Contact at Location: Name:

Phone #:

Topic to present on:

Provide health screenings?   ☐ Yes   ☐ No

Type of health screenings to
be conducted:

Items the resident needs to
supply:

Number of residents requested:

_____
Family Medicine PD/PC Signature   Date

_____
Internal Medicine PD/PC Signature   Date