

**UNIVERSITY OF EAST-WEST MEDICINE**  
**APPLICATION / REGISTRATION FOR CLINIC OBSERVER (CL 2)**

Student Name: \_\_\_\_\_ ID #: \_\_\_\_\_ Email: \_\_\_\_\_ Start Term: \_\_\_\_\_

**Statement of Understanding for Clinic Instruction (Language Requirements)**

*As a student at UEWM, participating in the MSTCM clinical training program as an intern (level CL2-CL7), I acknowledge through this agreement that, pursuant of CCR Section 1399.435, I am entitled to receive clinical training in the language that I am fluent in and conversant with (in this case, either English or Mandarin Chinese). I acknowledge that I am required, as per this agreement to register for clinic shifts with instructors that speak the language that I am fluent in. I also understand that, whether or not these instructors are readily known to me, I shall be given a list of suitable supervisors capable of fulfilling this requirement prior to my registration in the clinical training program in any given semester.*

PROGRAM:  Chinese  English \_\_\_\_\_  
Student Signature \_\_\_\_\_ date \_\_\_\_\_

*For Office Use Only*

**¶ CLINIC ADMINISTRATOR**

CL1 Theater (30 Hrs)

Clinic Entrance Exam Passed: TCM:  Anatomy:  Acu. Point:

Clinic Handbook Contract signed:  Health Certificate signed:

Current CPR Certification: Exp. date: \_\_\_\_\_ OSHA certificate: Exp. date: \_\_\_\_\_

Current TB Skin Test/X-ray: Exp. date: \_\_\_\_\_ HIPAA certificate: Exp. date: \_\_\_\_\_

Evaluation Forms Submitted: Yes  No  Evaluation Test Passed: Yes  No

Clinic Administrator: \_\_\_\_\_  
Signature \_\_\_\_\_ date \_\_\_\_\_

**¶ REGISTRAR**

*Course Requirements (No more than two concurrent courses)*

BS 106 Human Anatomy  CM 113 Foundation of TCM I

CM 213 Foundation of TCM II  AC 211 Acupuncture I

AC 311 Acupuncture II  HB 212 Herbology I

HB 312 Herbology II (concurrent)

All course requirements met: Yes  No

Comments: \_\_\_\_\_

Registrar: \_\_\_\_\_  
Signature \_\_\_\_\_ date \_\_\_\_\_

Comment: \_\_\_\_\_

Dean's Signature (if needed) \_\_\_\_\_  
Signature \_\_\_\_\_ date \_\_\_\_\_

**¶ FINANCE**

**Payment record:**

**¶ CLINIC DIRECTOR:** \_\_\_\_\_  
Signature \_\_\_\_\_ date \_\_\_\_\_

**Note: The Application / Registration for Clinic will be processed once a week. Please check with the clinic manager for details.**