



# Help Train Your Future Doctor !

## We're looking for a few good "REAL" patients...

Thank you for your interest in the training of our medical students:

We appreciate your willingness and your time.

We will be asking for the following information when you call.

### Medical Diagnosis:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_

Medical Doctor: \_\_\_\_\_

Hospital / Clinic Name: \_\_\_\_\_

Dr.'s Address: \_\_\_\_\_

Dr.'s City, State: \_\_\_\_\_ Dr.'s Phone #: \_\_\_\_\_

**Authorization** for Dr. to release patient diagnosis and specific patient findings for use in the  
UCSD, School of Medicine, Student Skill Training Sessions

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Referred by: \_\_\_\_\_

All new "Real Patients" will be interviewed and have their medical findings verified to participate in the program.

If you have any questions, please contact me at the following numbers to discuss your case.

**Marty Becerril, D.C.,** Patient Resource Program Coordinator

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