

## MSFC Reproductive Health Externship Program Host Facility Externship Confirmation

Thank you for your commitment to providing medical students with training in abortion care as it relates to the full spectrum of reproductive health care services. Please provide the following information about the clinical opportunity arranged by the medical student listed below to observe/train at your facility. This information is intended to verify the clinical opportunities that will be provided to the student requesting funding through the MSFC Reproductive Health Externship Program.

Extern's Name: \_\_\_\_\_

Extern Start Date: \_\_\_\_\_ Extern End Date: \_\_\_\_\_

### Procedures

Please estimate the number of Surgical Abortions and Medical Abortions the student will receive exposure to during their externship at your facility. Also, please list the range of other reproductive health services this student will receive exposure to during their externship at your facility.

Number of Surgical Abortions: \_\_\_\_\_

Number of Medical Abortions: \_\_\_\_\_

Other Reproductive Health Services:

- Pregnancy Options Counseling
- Pelvic exams
- Pap smears
- Breast exams
- Contraception
- Ultrasound
- STD testing/counseling
- Pre-Natal/Post-Natal Care
- Colposcopy
- Other(s): \_\_\_\_\_

### Signature

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

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

Signed: \_\_\_\_\_

Signed By: \_\_\_\_\_

Title: \_\_\_\_\_

Phone number: \_\_\_\_\_ E-mail: \_\_\_\_\_

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