



Host Facility Confirmation Form

Reproductive Health Externship / Clinical Abortion Observation

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: _____

Preferred Pronouns _____

Externship Start Date: _____ **Externship End Date:** _____

Please estimate the number of Surgical Abortions & Medical Abortions the student will receive exposure to during their externship at your facility. List the range of other reproductive health services this student will receive exposure to during their externship.

Surgical 1st Trimester: _____ **Surgical 2nd Trimester:** _____ **Medication Abortion:** _____

Other Reproductive Health Services:

- | | |
|---|---|
| <input type="checkbox"/> IUD Placement | <input type="checkbox"/> Pre-natal Care |
| <input type="checkbox"/> Pregnancy Options Counseling | <input type="checkbox"/> Colposcopy |
| <input type="checkbox"/> Pelvic Exams | <input type="checkbox"/> Contraception |
| <input type="checkbox"/> Pap Smear | <input type="checkbox"/> Ultrasound |
| <input type="checkbox"/> Breast Exam | <input type="checkbox"/> LGBT Health Services |
| <input type="checkbox"/> STD Testing | |

Facility Name

Facility Address

Signature

Date

Signed by

Title

Email Address

Phone Number

Please return this form to:

Email
externs@msfc.org

Mail
MSFC Externship Program
PO Box 40935
Philadelphia, PA 19107

Fax
215-625-4848