



Student/Resident Experiences and Rotations in Community Health

Site Rotation Application

Applicant Information

Full Name: _____ Date: _____
Last First M.I.

SSN: _____

Current Address:

Street Address Apartment/Unit #

City State ZIP Code

Phone: () _____ Work / Cell: () _____

Email Address: _____

Permanent Address:

Street Address Apartment/Unit #

City State ZIP Code

Phone: () _____

Emergency Contact

Name Phone

Which address would you prefer your mail sent: Current Permanent

Education Background

Program Name

(Residency, University, or Medical School)

Department: _____

Advisor: _____ () _____
(Phone)

Academic Standing:

Student Internship Resident

Year: 1st 2nd 3rd 4th

Type of Degree:

D.O. M.D. N.P. P.A. D.D.
(Masters Level) (Masters Level)

Specialty:

I.M. F.P. OB/GYN Pediatrics

Other

Indication of the characteristics of the rotation for which you are applying

Type of Rotation:

Residency (residents) Clerkship (3rd year medical students)
 P.A. (physician assistants) Preceptorship (4th year medical students)
 N.P. (nurse practitioners)

Rotation Specialty: I.M. F.P. OB/GYN Pediatrics _____
Other

Location: Please rank in order of preference, the community health centers in which you prefer to rotate. Only rank those health centers that are an acceptable option.

_____ Canyonlands	_____ Clinica Adelante	_____ Copper Queen
_____ Desert Senita	_____ El Pueblo	_____ El Rio
_____ Gila Health	_____ Marana	_____ Mariposa
_____ Morenci	_____ Mountain Park	_____ Native Health
_____ North Country	_____ St. Elizabeth	_____ Sun Life
_____ United		

Number of Weeks: _____ Preferred _____ Minimum

Start and End Dates

	Start Date	End Date
Most Preferred	_____	_____
Moderately Preferred	_____	_____

Days of the Week: Monday Tuesday Wednesday Thursday Friday

Please answer the following questions and return the requested documentation with the application

Rotation Requirements Does your program have specific rotation requirements?
 Yes – Include a copy of the requirements
 No

Medical Liability Insurance: Does your program's medical liability insurance cover you during the rotation?
 Yes – (Participants must return a letter from program that documents their liability insurance coverage)
 No

Housing Will you need housing?
 Yes No

Transportation Do you have a car that you can use during your rotation?
 Yes No

Spanish Speaking Do you speak Spanish?
 Yes (Highly Fluent) Yes (moderately fluent) Yes (low fluency) No

NHSC Scholar Are you a National Health Service Corps (NHSC) scholar?
 Yes No

Arizona Resident Are you now, or have been a resident of Arizona?
 Yes No

Please return the application, a cover letter that includes a brief statement of purpose (less than one page), a copy of your immunization records, and a reference letter from school / program addressing insurance liability coverage.



Mail or Fax: Wendy Recinos

Search Coordinator

Arizona Association of Community Health Centers

320 East McDowell Rd Ste., #320

Phoenix, AZ 85004

Fax: (602) 252-3620