Western North Carolina
Community Health Services

Clinical Rotation Request Form

Requested Rotation Dates:

#of hours requested:

Length of rotation:

First Name

Last Name

Address

Phone Number

Email Address

Name of Educational Institution

Clinical Rotation Coordinator Name

Contact Email and Phone #:

Purpose of Clinical Rotation

Degree/Certification Pursuing

Language Proficiencies

Level of Patient Contact Requesting (select one)

☐Observation only ☐Direct Patient Contact

Applicants approved for a clinical rotation at WNCCHS must meet credentialing requirements at WNCCHS prior to being on-site.

Attach a Curriculum Vitae (CV) or resume along with a Personal Statement outlining what qualities and skills you will bring to your rotation at WNCCHS, how rotating at WNCCHS will prepare you for future practice and why you specifically wish to complete your rotation at WNCCHS.

Completion of the student clinical request form does not guarantee placement.

**********For WNCCHS Clinical Rotation Selection******************

Status of Request: ☐Approved ☐Denied

Reviewed by Clinical Officer

Date

☐Submitted to HR

Date