Western North Carolina Community Health Services
Clinical Rotation Request From

Start Date of Rotation: End Date of Rotation: # of Hours Requested:

First Name: Last Name:

Address:

Phone Number:

E-mail:

Name of Institution:

Contact Person:

Contact Email and Phone number:

Purpose of Rotation:

Degree Pursuing:

Language Proficiencies:

Level of Patient Contact Requesting (select one):

◯ Observation (OBS) only ◯ Direct Patient Contact (DPC)

Applicants approved for a Clinical Rotation at WNCCHS will need to submit the following for approval prior to the rotation:

OBS & DPC: ☐ PPD Date: Results:

or if applicable – copy of Chest X-Ray Report

DPC:

Blood Borne Pathogen Training

☐

Liability Insurance

☐

Hepatitis B Immunization Dates Date: Date: Date:

☐

Attach a Curriculum Vitae and 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.

**********FOR WNCCHS CLINICAL ROTATION SELECTION COMMITTEE**********

Status of Request: ◯ Approved ◯ Denied

Reviewed by Appropriate Clinical Director: Date:

Submitted to Director of Human Resources: Date:

FOR HR COMPLETION ONLY: Current Contract ORIENTATION DATE:

☐ Yes ☐ No

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