# Application for Resident and Student Clinical Rotations

## APPLICANT INFORMATION

Name (First, Middle, Last): ______________________________________________

Home Street Address: ______________________________________________

Home City, State, Zip Code: ______________________________________________

Email accessible prior to/during rotation: ______________________________________________

Contact Phone: ______________________ Social Security Number: ______________________

Date of Birth: ______________________ Gender: _____ Male _____ Female

**School/Program**: _____MD _____DO _____NP _____PA ____Residency Other: ______________________

Year of School/Program: ___1st ___2nd ___3rd ___4th Other: ______________________

**If Applicable:** License #: ______________________ Type: ______________________ State issued: ______________

NPI #: ______________________ DEA#: ______________________

## EMERGENCY CONTACT (Please notify the Medical Staff Office of any changes)

Name: ______________________________________________

Relationship: ______________________ Contact phone: ______________________

## EDUCATION

Name of School or Program: ______________________________________________

School's Address: ______________________________________________

School's Phone Number: ______________________ Expected Graduation (Mo/Yr): ______________

School's Program Coordinator or Director: ______________________________________________

## ROTATION SCHEDULE AND SUPERVISING PHYSICIAN (if known)

Rotation Specialty: ______________________ Supervising Physician: ______________________

Rotation Dates: Begin (Mo/Day/Year): ______________ to (Mo/Day/Year) ______________________

Supervising Physician on Staff (if known): ______________________________________________

## APPLICANT'S CERTIFICATION

I hereby certify that the information I submit in the application is complete and correct to the very best of my knowledge. I agree to abide by all SIHF Healthcare policy and procedures.

Signature of Applicant: ______________________________ Date: ______________________

## OTHER DOCUMENTATION

Please also provide: Proof of health insurance and COVID vaccine, immunization records, letter of good standing and a copy of your university/college photo ID.

Return completed form along with other required documents to Melissa Hunter at mhunter@sihf.org.
For questions, please contact Melissa at 618-979-4968.