SIHF HEALTHCARE
YOUR HEALTH. OUR MISSION.

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 Kay Tolson ktolson@sihf.org
For questions, please contact Kay at 618.397.3303.