



# Olathe Health Physicians

## Application for Professional Student Clinical Rotation

Thank you for your interest in completing a clinical rotation with an Olathe Health Physicians Provider. Please complete this application in its entirety in order to be considered for placement. Send completed applications via email to [OHPstudents@olathehealth.org](mailto:OHPstudents@olathehealth.org). All applications will be reviewed within 3 weeks of being received. If you are accepted into a student rotation position, you will be contacted via email. If you have any questions, please contact us at 913.355.3654.

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Medical Student \_\_\_\_\_ year

Physician Assistant Student

Advanced Practice Registered Nurse Student

Other Student: \_\_\_\_\_

Home Address: \_\_\_\_\_

Cell Phone Number \_\_\_\_\_ Email: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

How many professional student rotations will you have completed prior to the requested dates? \_\_\_\_\_

School/Program Name: \_\_\_\_\_

School/Program Address: \_\_\_\_\_

School/Program Contact Name and Phone Number: \_\_\_\_\_

Clinical Rotation Dates Requested: \_\_\_\_\_

Clinical Rotation Specialty Requested: \_\_\_\_\_

Please list up to three Olathe Health Clinics where you would like to complete your rotation:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

Have you already contacted an OHP clinic or provider for this rotation request?  Yes  No

If yes, which clinic(s)/provider(s): \_\_\_\_\_

Is there any additional information you want to share? \_\_\_\_\_

I attest that all information above is accurate and true. I attest that I am in good standing with my professional program.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_