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. All applications will be reviewed within 2 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: _____

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: _____

School Contract Active ☐ Clinic/Provider Accepted _____ Student Packet Sent ___/___/_____

OHP Leadership Approval: _____

Clinic Manager Approval: _____

Supervising Preceptor Provider Approval: _____