

# Duncan Regional Hospital



## APRN

# Clinical Rotation Application

### Instructions

**Step 1:**

Obtain prior verbal acceptance by provider in which you wish to do your clinical rotation, complete attached form with provider signature.

**Step 2:**

Complete and bring the Clinical Rotation Application to the Education Office for review. Applications may also be emailed to [vera.budlong@duncanregional.com](mailto:vera.budlong@duncanregional.com). An additional phone interview may be required.

**Step 3:**

Notification of approval will be made by the Education Department with input from the Application Committee and notified of their acceptance status. Upon notification applicants will be scheduled for processing and orientation.



## EDUCATION PRACTICUM AGREEMENT

As a student in the \_\_\_\_\_ program, I hereby accept this student in a clinical preceptorship as a part of an educational practicum at Duncan Regional Hospital or Solutions Practice Management.

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Student Name**

\_\_\_\_\_  
**Student Signature**

\_\_\_\_\_  
**Provider Name**

\_\_\_\_\_  
**Provider Signature**



## APRN Clinical Rotation Application

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Preferred Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Male  Female

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_

In case of an emergency, contact: Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

Name of School/Program Specialty: \_\_\_\_\_ Expected Graduation Date \_\_\_\_\_

BSN/ASN program attended: \_\_\_\_\_ Highs School Attended: \_\_\_\_\_

Have you ever been employed by DRH, Solutions Practice Management or JCH: Yes  No

If Yes, pleas list dates and department: \_\_\_\_\_

Name of provider that has approved your Clinical Rotation: \_\_\_\_\_

Are you related to a current DRH, Solutions Practice Management or JCH team member: Yes  No

If yes, please list name and department: \_\_\_\_\_

I have read and understand the information on the Information Sheet. Should I need medical attention during or as a result of this job shadowing experience, I assume full responsibility for any treatments deemed necessary. I assume responsibility of all medical costs which result and release Duncan Regional Hospital of all liability. I give the facility at which job shadow is being conducted permission to release my telephone number or contact instructions to the requested department. While I am job shadowing at any Duncan Regional Hospital site, I realize that all healthcare information, patient/resident care and records are a confidential matter. All information exchanged while I am observing must be held in strictest confidence. I will only observe patient care and the role of the healthcare provider.

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

Please submit application to:  
Duncan Regional Hospital  
Attn: Vera Budlong, Education Dept  
P.O. Box 2000  
Duncan, OK 73534  
Phone: 580-251-8894 \* Fax: 580-251-8892

### Duncan Regional Hospital Use

- Application Received: \_\_\_\_\_
- Application
  - School Contract
  - Applicant Accepted
  - Confidentiality Agreement
  - Attended Orientation
  - Badge
  - Education Paperwork Complete