DRH Health

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@drhhealth.org
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 DRH Health 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 DRH Health 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 DRH Health 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:
DRH Health
Attn: Vera Budlong, Education Dept
P.O. Box 2000
Duncan, OK 73534
Phone: 580-251-8817 * Fax: 580-251-8892

Duncan Regional Hospital Use

Application Received: _____

- ☐ Application
- ☐ School Contract
- ☐ Applicant Accepted
- ☐ Confidentiality Agreement
- ☐ Attended Orientation
- ☐ Badge
- ☐ Education Paperwork Complete

Updated 3/21