Tanana Chiefs Conference

Clinical Staff Office
Chief Andrew Isaac Health Center
1717 West Cowles Street • Fairbanks, AK 99701
(907) 451-6682 x3042 (P) • (907) 459-3811 (F)

Student Rotation Application

Please complete this application for consideration and return by email with a CV/resume to whitney.paolino@tananachiefs.org. Due to high demand, incomplete applications will not be processed. Rotation requests require a lengthy review and approval process, please plan accordingly.

SECTION I: APPLICANT INFORMATION

Full Name (first, middle and last):_____

Preferred name:_____ Gender: ☐Male ☐Female

Date of Birth (mm/dd/yyyy):_____

Mailing Address:_____

Physical Address (if different from mailing):_____

Phone (primary):_____ Phone (secondary):_____

Email:_____

How would you prefer TCC communicate with you: ☐Email ☐Phone call/message

Ethnicity (select all that apply):

☐American Indian ☐Alaska Native ☐African/American ☐Asian ☐Caucasian
☐Native Hawaiian ☐Pacific Islander ☐Hispanic ☐Other_____

Emergency Contact Name:_____ Emergency Contact Phone:_____

Emergency Contact relationship:_____

SECTION II

Are you a current or former TCC employee?_____

How did you hear about us?_____

Are you from Alaska, or do you have any ties to an Alaska community?_____

_____

_____

Why are you interested in a clinical rotation at TCC?_____

_____

_____

_____

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SECTION III

The Alaska AHEC Program's funding agency (HRSA) requires that we collect the following demographic information:

Would you consider your background to be educationally disadvantaged?*_____
Would you consider your background to be economically disadvantaged?**_____
What is your veteran status?_____
Birthplace or Childhood Residence (city & state):_____

*"Educationally disadvantaged" individual comes from an environment that has inhibited the individual from obtaining knowledge, skills and abilities required to enroll or graduate from a health professional training school. Examples include attending a small rural high school or being the first in your family to attend college.

**"Economically disadvantaged" individual comes from a family with an annual income considered low income by the federal government. Examples include those who qualify for low-cost or free school lunches.

SECTION IV: APPLICANT EDUCATION INFORMATION

Current School/College/University:_____
City and State:_____
Major:_____ Degree Type or intended:_____

At time of you rotation, indicate your standing:

☐Undergraduate: list year (1-4)_____ ☐Graduate: list year (1-7)_____
☐Resident: list year (1-4)_____ ☐Other:_____
Anticipated month and year of graduation:_____

For Rotation Requests:
School Coordinator Name: _____ Phone:_____
Email:_____

School Contact for Memorandum of Agreement (MOA):_____
Email:_____ Phone:_____

What level of preceptor does your program allow?

☐PA-C ☐NP ☐MD ☐DO ☐Other_____
Does your program allow single or multiple preceptors? ☐Single ☐Multiple

Does your program allow telehealth visits as part of your rotation? ☐Yes ☐No
*Please note, telehealth visits are currently imbedded into providers daily/weekly schedules

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SECTION VI: PRIMARY ROTATION INFORMATION

Rotation start date (mm/dd/yyyy):_____ Rotation end date (mm/dd/yyyy):_____
Estimated days/hours per week:_____
Rotation Hours needed:. Percentage of program clinical rotation hours completed by this time:_____
Course Title during rotation dates:_____
If available, are you agreeable for rotation at rural clinic sites?_____
Any additional information to assist our coordinators in the review of your request?_____

_____

_____

Please select discipline(s) needed for rotation:

☐Medical (MD/DO)	☐Nurse Midwife	☐Nurse Practitioner
☐Physician Assistant	☐Nursing	☐Medical Assistant
☐Behavioral Health	☐Dental	☐Dietetics
☐Health Administration	☐Internal Medicine	☐Laboratory
☐Optometry	☐Orthopedics	☐Pediatrics
☐Pharmacy	☐Physical Therapy	☐Radiology
☐Surgery	☐WIC	☐Women's Health/OBGYN
☐Other:_____		☐Family Medicine

SECTION VII: SECONDARY ROTATION REQUEST

Each learner will be approved for up to three months at a time, and further rotations beyond that timeframe will only be offered if there are no other suitable student candidates using those slots

Rotation start date (mm/dd/yyyy):_____ Rotation end date (mm/dd/yyyy):_____
Estimated days/hours per week:_____
Rotation Hours needed:. Percentage of program clinical rotation hours completed by this time:_____
Course Title during rotation dates:_____
If available, are you agreeable for rotation at rural clinic sites?_____
Any additional information to assist our coordinators in the review of your request?_____

_____

_____

Please select discipline(s) needed for rotation:

☐Medical (MD/DO)	☐Nurse Midwife	☐Nurse Practitioner
☐Physician Assistant	☐Nursing	☐Medical Assistant
☐Behavioral Health	☐Dental	☐Dietetics
☐Health Administration	☐Internal Medicine	☐Laboratory
☐Optometry	☐Orthopedics	☐Pediatrics
☐Pharmacy	☐Physical Therapy	☐Radiology
☐Surgery	☐WIC	☐Women's Health/OBGYN
☐Other:_____		☐Family Medicine

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SECTION VIII

Have you ever been charged or convicted of a felony, misdemeanor or offense other than a minor traffic violation? ☐Yes ☐No

If yes, please explain:_____

_____

_____

Do you have a valid Alaska Driver's License? ☐Yes ☐No Number:_____

SECTION IX

Please read the following carefully and initial each paragraph:

☐I understand that there is no compensation for shadowing/interning at Tanana Chiefs Conference (TCC).

☐I hereby authorize TCC to thoroughly investigate my education, criminal record and other matters related to my suitability for shadowing or interning at TCC. I hereby release TCC and all other persons or entities from any and all claims, demands, or liabilities arising out of or in any way related to such investigation or disclosure.

☐I understand that nothing contained in the application or conveyed to me during any interview that may be granted is intended an employment contract, implied or explicit, between me and TCC.

☐I understand that as a shadow or intern I would not be entitled to any pay, compensation or benefits.

☐I hereby certify that I have not knowingly withheld any information that might adversely affect my chances for shadowing or interning and that the answers given by me are true and correct to the best of my knowledge. I further certify that I, the undersigned, have personally completed this application. I understand that my omission or misstatement on this application or on any documents used to secure shadowing or interning shall be grounds for rejection of this application or for immediate discharge, regardless of the time elapsed before discovery. Non-disclosure of criminal record could result in possible denial of shadow or student intern status. My signature below certifies that I have read and understand this complete page and agree to the terms and conditions outlined in this document.

Printed Name	Signature	Date

Updated 3.4.22