| F:\CCHC\New folder\cchc-logo-actual.gifHealthcare Related Student application 1789 Elm Street Suite A  Dubuque, Iowa 52001  We’re excited to have you join us! Please complete this form and sign below.  Contact **Becky** for any questions regarding student opportunities at **(563) 690-2858 or rwunderlin@crescentchc.org.** | | | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Applicant Information | | | | | | | | | | | |
| Name: | | | | | | | | | | | |
| Phone: | | | | | | | Alternate Phone: | | | | |
| Email address: | | | | | | | | | | | |
| Current address: | | | | | | | | | | | |
| City: | | | | State: | | | | | ZIP Code: | | |
| Mailing address (if different than your current address): | | | | | | | | | | | |
| City: | | | | State: | | | | | ZIP Code: | | |
| List the language(s) you speak, read and/or write: | | | | | | | | | | | |
| Emergency contact (name and number): | | | | | | | | | | | |
| Health restrictions (please list i.e., asthma, bad back…): | | | | | | | | | | | |
| Do you have a valid I.D? Yes No | | | | | | Do you have reliable transportation? Yes No | | | | | |
| SCHOOL Informaiton | | | | | | | | | | | |
| Name of school you currently are attending: | | | | | | | | | | | |
| Anticipated graduation date: | | | | | | | Semesters completed: | | | | |
| Address: | | | | | | | | | How long?: | | |
| Phone: | | | City: | | | | | | State: | | |
| ZIP Code: | | | Clinical Instructor: | | | | | | | | |
| Previous Clinical Rotations/Internships | | | | | | | | | | | |
| Organization/Preceptor: | | Position/Major responsibility: | | | | | | | Dates of rotation (month/year)  From: To: | | |
|  | |  | | | | | | |  | | |
|  | |  | | | | | | |  | | |
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|  | |  | | | | | | |  | | |
| REFERENCES | | | | | | | | | | |
| Please provide a name, number and email address for each: | | | | | | | | | | |
| Availability | | | | | | | | | | | |
|  | Monday | Tuesday | | | Wednesday | | | Thursday | Friday | Saturday | |
| From: |  |  | | |  | | |  |  |  | |
| To: |  |  | | |  | | |  |  |  | |
| How many hours do you need to fulfill this rotation? (please circle) 1-5 6-10 11-15 16-20 | | | | | | | | | | | |
| list skills, interests, and training | | | | | | | | | | | |
| Skills: | | | | | | | | | | | |
| Interests: | | | | | | | | | | | |
| Training: | | | | | | | | | | | |
| To place you in the most rewarding student experience, indicate the areas listed that you would be interested in (Check all that apply):   * Family Medicine * Community Health * Women’s Health * Pediatrics * Geriatrics * Other (please explain):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | |
| What is your primary reason you want to be a student at Crescent Community Health Center? | | | | | | | | | | | |
| Please provide us with any additional information about yourself you feel would be relevant to your selection: | | | | | | | | | | | |
| How did you find out about our student opportunities? | | | | | | | | | | | |
| I understand the information that I have provided will be kept confidential and available only to the Directors of the project that I am volunteering for and those designated by them for the selection and training of volunteers. This information was requested in order to determine your experience, availability, motivation and needs for volunteering.  I agree to sign a strict **confidentiality statement** and abide by it when participating as a Crescent Community Health Center Volunteer.  I agree to do my best to be a good representative of Crescent Community Health Center. | | | | | | | | | | | |
| By signing below, I understand the above information and I certify that this application is true and complete to the best of my knowledge.  Signature: Date: | | | | | | | | | | | |