Personal Information

Last Name       First Name       Middle

Email Address   Please provide your complete email address; clearly indicate capital letters and numbers.

Current Mailing Address

City          State       Zip Code

Daytime Phone Number / Cell Phone Number

School/Program Information

I am currently enrolled in:
☐ Medical School, YEAR____   ☐ Residency, YEAR____   ☐ Physician Assistant Program   ☐ Nurse Practitioner Program

Name of School/Residency Program

When do you anticipate completing your training?

School/Program Mailing Address:

City          State       Zip Code

School/Program Contact: Name & Title   Email   Phone

Rotation Information

Desired Rotation:  ☐ Family Practice   ☐ Internal Medicine   ☐ Pediatrics   ☐ Elective/Other: _______________________

Rotation Dates: (specify exact inclusive dates, please):

1st Choice:     Beginning: ______________________   Ending: ______________________   Month / Day / Year

2nd Choice:     Beginning: ______________________   Ending: ______________________   Month / Day / Year

3rd Choice:     Beginning: ______________________   Ending: ______________________   Month / Day / Year

Days of the Week (circle choice): Daily or Mondays Tuesdays Wednesdays Thursdays Fridays

Time of Day (circle choice): All day Morning session only Afternoon session only

Please list most recently completed rotations (if any):

Location/Preceptor: Type of Rotation/Specialty: Dates:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

[JRCHC Rotation Request Form] [v.2019]
Short Answer Information (you may also attach a cover letter or personal statement with this application)

1. How did you hear about Jericho Road Community Health Center?

2. Describe your career goals and intended specialty. Where do you see yourself in five years? How would a rotation at JRCHC impact those goals?

3. Describe your interest and experience in providing health care to underserved populations.

4. Please list any additional information that you think would be helpful for us to know about you, including relevant skills and language proficiencies.

Emergency Contact Information:

Contact Name: ___________________________ Relation to you: ___________________________

Daytime Phone: ___________________________ Alternate Phone: ___________________________

Signature

I certify that all the information in this application is true and accurate.

Applicant signature ___________________________ Date __________

Mailing Instructions

Please mail or email all application materials to the address below:

Jericho Road Community Health Center
Attn: Amanda Knecht
182 Breckenridge Street
Buffalo, NY 14213

Or email to: amanda.knecht@jrchc.org