WAKE FOREST SCHOOL OF MEDICINE
APPLICATION FOR VISITING PA STUDENTS

When completed, print and scan to: lcook@wakehealth.edu or fax to 336-716-4432, attn.: Lori Cook

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SECTION I -- To be completed by visiting student requesting rotation

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FULL NAME

_____

First Middle Last

Date of Birth:

Address:

City:

State & Zip Code:

Phone:

Email:

Fax:

PA School:

PA School Address:

City:

State & Zip Code:

Why are you interested in coming to Wake Forest Baptist Health for a clinical rotation?

ROTATIONS(S) REQUESTED

Specialty/Department:

Rotation Type/Course:

Preceptor (if known):

Start Date:

End Date:

Specialty/Department:

Rotation Type/Course:

Preceptor (if known):

Start Date:

End Date:

Specialty/Department:

Rotation Type/Course:

Preceptor (if known):

Start Date:

End Date:

Specialty/Department:

Rotation Type/Course:

Preceptor (if known):

Start Date:

End Date:

SECTION II – To be completed by the requesting student's Clinical Coordinator/Director, PA Program Director (or comparable official) of the institution where the student is enrolled.

	YES	**NO**
The above-named student is in good standing	___	___
The student will pay tuition at their home institution and is applying for this rotation with the permission of their PA Program	___	___
Malpractice insurance (min. required $1M/$3M) covers the student away from their home institution.	___	___
Personal health coverage is in effect away from their home institution	___	___
OSHA training is completed annually at their home institution	___	___
The student is approved to complete this rotation for credit	___	___

Signature:_____

Title:_____

Date:_____

Phone:_____

Email:_____