Choctaw Nation

Health Services

Family Medicine Residency
Medical Student Rotation Application Form

Submit completed application to kdbrock@cnhsa.com and ettaylor@cnhsa.com

Name: _____ SSN: _____-_____-_____

First Middle Last

(We need your SSN in order to perform a criminal background check which is required in Federal Institutions.)

Date of Birth: _____/_____/_____ Are you a U.S. citizen? ☐ yes ☐ no

Address: _____

Street City State Zip Code

Have you ever been charged or convicted of a felony? ☐ yes ☐ no

Name of Medical School and year of training: _____

What field(s) of medicine are you interested in? _____

Is this an Audition Rotation? ☐ yes ☐ no

If not, what clinical rotation are you requesting? _____

Is this an elective or a core rotation? ☐ yes ☐ no

What dates are you requesting for this rotation? (please list up to 3) _____

_____ _____

I give permission for a criminal background check to be completed. (initial) _____

I understand that this rotation must be approved by the Site Director. (initial) _____

I voluntarily give permission for a urine drug screen prior to my rotation. (initial) _____

Signature: _____ Date: _____

Completed by CNHSA staff

Approved: ☐ yes ☐ no

Signature of Site Director: _____ Date: _____

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