

PPCWNY Rotation Request Form

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 this type of program: _____

Name of School/Residency Program _____ When do you anticipate completing your program? _____

School/Program Mailing Address: _____

City _____ State _____ Zip Code _____

School/Program Contact: Name & Title _____ Email _____ Phone _____

Rotation Information

Desired Rotation: Abortion Family Planning

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

1st Choice: Beginning _____ Ending: _____
Month / Day / Year Month / Day / Year Required Hours (if appl.)

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

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

Days of the Week *(mark choice)*: Daily or Monday Tuesday Wednesday Thursday Friday

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

Please list most recently completed rotations *(if any)*:

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

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Short Answer Information *(you may also attach a cover letter or personal statement with this application)*

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

2. Describe your interest and experience in providing abortion care.

3. 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 email all application materials to the address below:

ClinicalRotations@PPCWN Y.org