HOPE CLINIC
a community health center

Date: _____

Application for Clinical Rotation

Applicant's Name:_____

Address: _____

Telephone Number: _____

Email Address:_____

Are you a U.S. Citizen or authorized to work in the U.S.?
_____Yes _____No

Name of College/University Attending: _____

Program Name:_____

Number of Clinical Rotations previously completed and name of facility: _____

_____

_____

Certificate/License(s):_____

Type of Rotation Requested:
☐ Pediatrics
☐ Adult/Family Medicine
☐ Other (_____)

Number of Hours Requested: _____

Approx. Start & End Dates:_____

Semester requested (Spring, Summer, Fall): _____

Check any language(s) that you speak fluently:
☐ Cantonese ☐ Vietnamese ☐ Mandarin ☐ Spanish ☐ Other: _____

How did you hear about HOPE Clinic?

Please explain your interest in HOPE Clinic and let us know why you would like to complete your clinical rotation here?

Please submit your application with a copy of your resume to atram@hopechc.org with the subject line- Clinical Rotations.

Due to the high volume of applicants, only candidates selected for interviews will be contacted. Thank you for your interest in the Asian American Health Coalition dba HOPE Clinic!

Equal Opportunity Employer

It is the policy of the AAHC dba HOPE Clinic to practice and ensure fair and equitable employment opportunities to all individuals, regardless of race, color, religion, sex, national origin, disability, veteran status, or age.