Utica Park Clinic Student Clinical Program Application

Phone: 918-579-3919 Fax: 918-579-1159
Return to: UPC Human Resources, 1145 S. Utica, Suite 120, Tulsa, OK 74104
Email to HR: melissa.willis@hillcrest.com
***Form must be submitted at least 30 days prior to requested clinical observation date(s).**

Date:_____

Full Name:_____

Address:_____

City:_____**State:**_____**Zip:**_____

Are you at least 18 years of age or older? (circle) Yes No

Home Phone:_____**Cell Phone #:**_____

E-Mail Address:_____

Education:
Are you currently enrolled in a Pre-medical program? (circle) Yes No
Are you currently enrolled in a Pre-nursing Program? (circle) Yes No

Name of the University and/or technical school you are currently attending:
_____
Anticipated date of graduation: _____

Please include a copy of your immunization records: All applicants must have a current MMR, varicella and influenza vaccine during flu season (between September and May).

Please list the dates you anticipate observing: From: _____**to**_____
Which UPC Provider(s) do you anticipate observing?

1) _____ 2) _____

3) _____

Days and times you will be observing in the clinic:

__Mon (___am - ___pm)**, __Tues** (___am - ___pm)**, __Wed (**___am - ___pm)**,**
__Thurs (___am - ___pm), **__Fri** (___am - ___pm), **__Sat (**___am - ___pm)**, __Sun (**___am - ___pm)

Have you ever been employed by Hillcrest HealthCare System? __ No __ Yes What year? _____ **What department?** _____

Have you ever been found guilty, pled no contest, or had a conviction for any criminal act other than a minor traffic violation? __No __Yes (If "Yes" explain)
_____

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Are you able to perform the duties of the position for which you are applying with reasonable accommodations? __Yes __No (If "No" explain)

_____

_____

EDUCATIONAL REFERENCES:

_____

(Name) **(Address)** **(Phone)**

_____

(Name) **(Address)** **(Phone)**

EMERGENCY CONTACT:

_____

(Name) **(Phone)** **(Relationship)**

_____

(Place of Employment) **(Business Phone)**

_____

(Business Address)

_____

(Applicant's Signature)

Administrative purposes only below this line

☐ **Approved** **Location Assigned:** _____

☐ **Denied: Reason:** _____

Clinical Student Affiliation Agreement	**Clinical Student Non-Affiliation**
☐ Affiliation Verified	☐ Background Check Release
☐ Security Agreement	☐ Immunization Records Verified
☐ Confidentiality Statement	☐ EHS Clearance if applicable
☐	☐ HIPAA Training
☐	☐ Security Agreement
☐	☐ Confidentiality Statement

Supervising Provider agrees to follow the UPC policy on the Student Clinical Program and accepts the student for the period outlined above.

Provider Signature: _____
