TopLine MD® Alliance
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CLINICAL ROTATION / SHADOWING APPLICATION

Instructions: Download and complete this application. After completing the form, email it along with required documents from your school to: Patricia Toussaint (Office Manager) ptoussaint@femwell.com, office number: 407-216-2121

Student Information:		
Full Name:	Phone Number:	Email Address:

Educational Program	
School / University:	
Program Type (NP, PA, MD, etc.):	Program Coordinator Name:
Program Coordinator Email:	Program Coordinator Phone:

Rotation Details	
Requested Start Date:	Requested End Date:
Total Clinical Hours Required by Program:	Rotation Type:
	☐ Clinical Rotation ☐ Shadowing

Interest Statement
Why are you interested in a Women's Health clinical rotation at our practice?

Required Documents to Submit with Application
☐ Resume ☐ Cover Letter ☐ HIPAA Training Certificate

Program Acknowledgements
☐ I understand only two students are accepted at a time.
☐ I understand that my application will be reviewed and the office will contact me to schedule an interview if selected.
☐ I understand their is a clinical rotation honorarium for the first semester.
☐ I understand that the honorarium applies ONLY to clinical rotations and does NOT apply to shadowing.
☐ I understand additional semesters may be approximately $500 and will be evaluated individually.
☐ I understand that the honorarium applies ONLY to clinical rotations and does NOT apply to shadowing.
☐ I understand that a Non-Disclosure Agreement (NDA) must be signed before beginning the rotation.

Applicant Certification
☐ I certify that the information provided in this application is accurate and complete.

Applicant Signature:	Date: