PUYALLUP TRIBAL HEALTH AUTHORITY
MEDICAL STUDENT ROTATION APPLICATION

2209 East 32nd Street, Tacoma, Washington 98404
Tel: (253) 441-2634, Fax: (253) 441-2695

Please complete and send all forms (listed below) to Amy Lind, Residency Manager (alind@eptha.com). *We must receive all items listed below in order to review and consider your application.*

1. **Completed Application**
2. **Supplemental Questions**
3. **Release Authorization**
4. **Background Check Form**

PERSONAL INFORMATION

Last _____ First _____ MI _____

Street Address _____ City _____ State _____ Zip Code _____

Phone _____ Cell Phone _____ E-Mail Address _____

Are you Native American or Alaskan Native born in the U.S.? ☐ NO or ☐ YES If yes, which tribe? _____

****To ensure "Indian Preference," proof of enrollment must be attached to the application****

Have you ever been convicted of a felony? ☐ NO or ☐ YES, please explain: _____

MEDICAL STUDENT INFORMATION

College Education: _____ Graduation Date: _____

Medical School currently attending: _____ Start Date: _____ Graduation Date: _____

Requested rotation dates at PTHA: Start date: _____ End date: _____

Please provide your Rotation Coordinator contact information:

Name: _____

Phone: _____

Email: _____

List any licenses/certificates you have obtained: _____

Have you ever had a professional license or certification revoked or denied? ☐ No ☐ Yes, Explain: _____

Have you ever received a failing or incomplete grade or had to repeat a class during medical school? ☐ Yes ☐ No

If yes, please list the class(es) and explain:

COMLEX Scores: Please list ALL test dates, scores and test results for each exam.

COMLEX Level 1/USMLE Step 1: Test Date: _____ Score: _____ Pass ☐ Fail ☐

Test Date: _____ Score: _____ Pass ☐ Fail ☐

Test Date: _____ Score: _____ Pass ☐ Fail ☐

If you have an exam scheduled, but haven't taken it yet, please provide your scheduled exam date: _____

COMLEX Level 2, CE/USMLE Step 2, CK:

Test Date:______ Score: _____ Pass ☐ Fail ☐

Test Date:______ Score: _____ Pass ☐ Fail ☐

If you have an exam scheduled, but haven't taken it yet, please provide your scheduled exam date:______________________

COMLEX Level 2, PE/USMLE Step 2, CS:

Test Date:______ Score: _____ Pass ☐ Fail ☐

If you have an exam scheduled, but haven't taken it yet, please provide your scheduled exam date:______________________

PROFESSIONAL MEMBERSHIPS

Professional Memberships:

PROFESSIONAL EXPERIENCE

Organization Name: Address: Phone #:		Supervisor Name & Title: May we contact: ☐ Yes ☐ No	
Position Title:		Average Hours per Week:	Was this a volunteer position? ☐ Yes ☐ No
From:	To:	Reason for Leaving:	
DUTIES:			

Organization Name: Address: Phone #:		Supervisor Name & Title: May we contact: ☐ Yes ☐ No	
Position Title:		Average Hours per Week:	Was this a volunteer position? ☐ Yes ☐ No
From:	To:	Reason for Leaving:	
DUTIES:			

Organization Name: Address: Phone #:		Supervisor Name & Title: May we contact: ☐ Yes ☐ No	
Position Title:		Average Hours per Week:	Was this a volunteer position? ☐ Yes ☐ No
From:	To:	Reason for Leaving:	
DUTIES:			

SUPPLEMENTAL QUESTIONS

Please tell us why you are interested in completing your residency training at Puyallup Tribal Health Authority.

Please share your experiences working with underserved/underrepresented populations. If you do have any experiences working with or interacting with American Indian/Alaska Native populations, please make sure to include that.

Please share your inpatient hospital adult/family medicine and/or inpatient pediatrics experience and how if at all has been impacted by the pandemic.

Where do you currently see your path taking you? Are you looking to practice full spectrum family medicine and/or on practicing in an Indian Health Service shortage area? Do you anticipate pursuing an underserved career?

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING THIS APPLICATION

1. PTHA is an Equal Opportunity Employer while practicing native hiring preference according to law. PTHA does not discriminate on the basis of sex, age, race, color, religion, marital status, national origin, disability, and Veteran status.
2. Because of the large number of applications received, not everyone who applies for a rotation slot will be placed in a slot.
3. I authorize all previous employers/supervisors, including all persons with and for whom I have worked, to give PTHA's representative any and all information regarding my previous employment/education. I release PTHA and all previous employers/supervisors from liability for any damages that may result from furnishing information to PTHA.
4. I agree to conform to all PTHA Personnel Policies and Procedures.
5. I understand that a background check and/or a pre-employment or employment drug test may be required, prior to any employment offer.
6. I certify that I have answered truthfully and have not knowingly withheld any information relative to my application. I understand that any misrepresentation or material omission of this application will result in my being eliminated from further consideration. I further understand that, if accepted for employment, any misrepresentation or material omission which becomes known to PTHA, will result in immediate termination.

Student Applicant Signature Date

PUYALLUP TRIBAL HEALTH AUTHORITY
REFERENCE RELEASE AUTHORIZATION

I, _____, voluntarily consent and authorize any representative of the Puyallup Tribal Health Authority to obtain information from my current and previous employers, or other applicable sources pertaining to my employment and educational history. This authorization includes, but is not limited to; attendance records, educational background, work experience, length of employment, wage history, performance, disciplinary actions, performance evaluations and reason for separation from former employment.

I hereby authorize you to release such information upon request. It is expressly understood that any information given, is to be used for the purpose of determining my acceptability for employment with the Puyallup Tribal Health Authority.

I also hereby release you, the institution or establishment which you represent, including its officers, employees, and related personnel, both individually and collectively, from any and all liability for damages or claims, which may arise or result from any reference information gathered pursuant to this authorization.

This Authorization will continue in effect for one year, from the date of signature. A photocopy of the Authorization shall have the same force as the original.

_____ _____

PRINT NAME DATE

_____

SIGNATURE

PUYALLUP TRIBAL HEALTH AUTHORITY

2209 East 32nd Street, Tacoma, Washington 98404
Tel: (253) 593-0232 Ext: 516, Fax: (253) 593-3479

Background Investigations are completed through Washington State Patrol (WATCH) and/or another authorized and approved vendor of the Puyallup Tribal Health Authority. Only authorized personnel of the Puyallup Tribal Health Authority are allowed to submit and receive background check information.

AUTHORIZATION FOR RELEASE OF INFORMATION AND REQUEST FOR CRIMINAL HISTORY CONVICTION RECORD INFORMATION

I, _____ authorize all corporations, companies, credit agencies, educational institutions, law enforcement agencies, military services, D.M.V. records and former employers, to release information they have about me to the Puyallup Tribal Health Authority and/or affiliating agencies. I release them from any liability or responsibility for doing so, and I agree to indemnify them for any reason; furthermore, I authorize the procurement of an investigative consumer report and such a report may contain information about my background, character and personal reputation and that further information may be available upon written request within a reasonable amount of time. I have the authority to make the above request and release.

COMPLETE SECTION BELOW (please print legibly):

First Name | Middle Initial | Last Name | Alias/Maiden

Date of Birth | Social Security Number | Drivers License Number

Current Address / Street | City | State | Zip Code

County (Pierce, Thurston, King, etc.) | How Long

Previous Address / Street | City | State | Zip Code

County (Pierce, Thurston, King, etc.) | How Long

List the state and county of residences for the last ten (10) years: _____

Signature of Authorization **Date**