Regional Medical Center

Office Use Only

Student Listing: _____

Student Calendar: _____

Computer Access: _____

Sleep Room: _____

STUDENT INFORMATION

(PLEASE PRINT)

Today's Date: _____

BASIC INFORMATION:

Full Name: _____ Male ☐ Female ☐

Current Address: _____

Phone Number: (_____) _____-_____ Birth Date: _____/_____/_____

Email: _____Last Four Digits of SSN: _____

Responsible RMC Preceptor: _____

Dates Requested at RMC: _____/_____/_____ to _____/_____/_____

EDUCATION:

Current Level of Education: _____

Name of Current School: _____

Focus of Study: _____

Clinical Hours needed: _____ Focus Area of Rotation: _____

Tentative Graduation Month/Year: _____/_____

School Contact Name: _____

School Contact Phone: (_____) _____-_____ Email: _____

Other Rotations completed (please be specific):_____

_____

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Are you currently or have you ever been employed by RMC? _____

If yes, in what position? _____

Please check the areas you are interested in (check all that apply (if applicable)

☐ Emergency Department ☐ Family Practice ☐ Hospitalist ☐ Geriatrics ☐ Other

How did you hear about RMC? _____

EMERGENCY CONTACT:

Name: _____ Relationship: _____

Address: _____

Phone Number: (_____) _____-_____

ATTESTATION:

I hereby attest that the information submitted on this form is complete and correct to the best of my knowledge and belief.

_____ _____

SIGNATURE OF STUDENT **DATE**