



Student Name: _____

Student Type: _____

Preceptor/Dept.: _____

Sleep Room: _____

STUDENT INFORMATION

(PLEASE PRINT)

Today's Date: _____

BASIC INFORMATION:

Full Name: _____ Male ___ Female ___

Responsible RMC Preceptor: _____

Date(s) at RMC: ____/____/____ to ____/____/____

EDUCATION:

Current Level of Education: _____

Name of Current School: _____

Focus of Study: _____

Clinical Hours needed: _____ / Focus Area of Rotation: _____

Dates Attended: ____/____/____ to ____/____/____

Tentative Graduation Month/Year _____/_____

School Address: _____

School Contact Name: _____

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

Other Rotations completed (please be specific) _____

(If additional space is needed please continue on back of form)

PERSONAL INFORMATION:

Current Address: _____

Mailing Address (if different): _____

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



Student Name: _____

Student Type: _____

Preceptor/Dept.: _____

Sleep Room: _____

Email: _____ Last Four Digits of SSN: _____

Current Position _____

Current Employer: _____

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

If yes, in what position? _____

After Graduation, my professional aspiration is to work as a _____

At _____.

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: _____

Phone Number: (____) _____ - _____ Address: _____

ATTESTATION:

I hereby attest that the information submitted on this form is complete and correct to the best of my knowledge and belief. I have read the Student Orientation Manual and agree to abide by its regulations.

SIGNATURE OF STUDENT

DATE

SIGNATURE OF RESPONSIBLE PRECEPTOR

DATE

SIGNATURE OF RMC PERSONNEL (BELOW)
Cheri Heims, AA, CPCS, Credentialing Specialist

DATE