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| --- |
| **STUDENT SECTION** |
| Name: | Phone #: |
| Address: |
| City, State, Zip: |
| Email Address: |
| Birth Date (Needed for EMR Access): |
| **INSTITUITIONAL INFORMATION:** |
| Institute/Program Name (if applicable): |
| Institute/Program Contact: |
| Contact Email Address: |
| Phone #: | Start Date: End Date: |
| □ Observation □ Clinical Rotation □ Internship □ Externship |
| Number of hours needed: |
| **EMERGENCY CONTACT INFORMATION** |
| Name: | Relationship: |
| Phone #: |
| Any allergies and/or health conditions that we need to be aware of:  |
| Hospital Preference: |
| Vaccinations: *Student observes are not required to have MMR, Hep B & Flu;* ***COVID-19 is required of ALL students*** |
| [ ]  COVID-19 [ ]  MMR [ ]  Hep B [ ]  Flu |

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**THIS SECTION COMPLETED BY CPA**:

|  |  |
| --- | --- |
|  | CPA Location: |
|  | Name of Preceptor: |
|  | Medical Clearance (MMR, Hep B, COVID-19, Flu) |
|   | Clinical Affiliation Agreement on File |
|  | Completed Student Paperwork Packet |
|  | Signed Preceptor Agreement |
|  | ID Badge provided, if necessary |
|  | System access provided, if required  |