**Demographics**

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *Last First MI*

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *Street Address Apartment /unit #*

Cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you at least 18 years of age or older? YES [ ]  NO [ ]

Have you ever worked at a Hillcrest Hospital/UPC/OHI? YES [ ]  NO [ ]  If yes, When\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been found guilty, plead no contest, or had a conviction for any criminal act other than a minor traffic violation? YES [ ]  NO [ ]

If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Full number is needed for access purposes)

**School Information**

Name of the university, program, or technical school you are attending:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *Name Address/Location*

**Describe your current educational position:**

🞎 Medical Student: Year\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞎 APRN Student: Specialty\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞎 Resident/Fellow: Specialty\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞎 Medical Assistant Student

🞎 Nursing Student

🞎 PA Student: Specialty\_\_\_\_\_\_\_\_\_\_

**Program Director/instructor or contact name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anticipated date of graduation or program completion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Clinical Rotation Location Information**

**Clinic Location**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Office Manager**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Supervising Physician or APP** (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please List the dates and time you plan to be in the clinic:**

Monday \_\_\_(am,pm) Tuesday\_\_\_(am,pm) Wednesday\_\_\_(am,pm) Thursday\_\_\_(am,pm) Friday\_\_\_(am,pm)

**Dates of your anticipated preceptorship:** Start\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ End \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Epic EHR Experience**

Have you had Experience using the Epic EHR? 🞎 No 🞎 Yes.

**Clinical Preceptor Acknowledgement**

 If yes, describe your training and whether it was inpatient training, ambulatory training, or both.

**Acknowledgment**

This is to acknowledge that (Name of school) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Maintains current copies of the following documents for the preceptor:**

* School attestation of current vaccinations
* Evidence of liability insurance
* Current BLS

**Signature:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Clinical Preceptor’s Signature**Date*

**For Preceptor Program - internal use only**

🞎 Approved 🞎 Not Approved \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

 *Reviewers Signature Date*

**Confirmed Start Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Conformed End Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INFORMATION CONFIDENTIALITY AND SECURITY AGREEMENT (ICSA) signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Clinic Location**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Office Manager**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Supervising Physician or APP** (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***MA student’s only*:** Program director notified\_\_\_\_\_\_\_\_\_(date)

1. Referred to HR for Lawson access: \_\_\_\_\_\_\_\_\_\_ (Not for SCO’s)

 *Date*

2. Referred to IT for Epic Access: \_\_\_\_\_\_\_\_\_\_ (Not for SCO’s)

 *Date*

3. Application Referred to Clinic Manager*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

 *Date*

**For Human Resources only**

Lawson assignment created: \_\_\_\_\_\_\_\_\_\_\_\_\_ Lawson by whom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *Date initial*

IT access requested on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student Contractor ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For IT only**

Epic access created: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ By whom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *Date Initial*

Date Epic training is assigned: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Epic training completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *Date Date*

What Epic training module was assigned (describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_