INFIRMARY HEALTH

Student Intake Form

Personal Information

First Name: _____ Last Name: _____

Address: _____ City/State/Zip: _____

Preferred Phone: _____ Email: _____

☐ I am 18 years of age or older ☐ I am a High School Student ☐ I am a College Student

☐ I would like to observe ☐ I need clinical hours Is this for school credit? ☐ Yes ☐ No

Education & Rotation Information

Name of School: _____ Discipline/Program: _____

Desired Start Date: _____ End Date: _____ Total # of Hours Needed: _____

Student #: _____ Instructor/ Faculty Name: _____

Instructor Email Address: _____ Phone: _____

Which Infirmary Health Site would you like to be located? _____

Infirmary Department and Employee who approved this rotation: _____

Signature _____ Date _____

IH Office Use Only:

☐ Current Infirmary Health Employee Preceptor/Supervisor _____

Location/Unit Placed _____