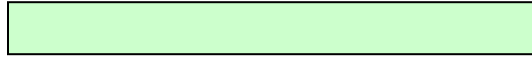


PLEASE COMPLETE INFORMATION BELOW AND TURN IN ON 1ST DAY TO ORIENTOR



Date: _____

Supervisor: _____

EMERGENCY CONTACT - This information will be kept with the Department Staff Phone List in case an emergency situation arises while you are at work.

YOUR NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP _____

PHONE NUMBER: _____ EMPLOYEE # _____

EMERGENCY CONTACT PERSON'S NAME _____

PHONE # _____

PERTINENT MEDICAL HISTORY: (i.e. medication, allergy reactions) If you do not want information listed, please inform a peer in your area about treatments or precautions relating to any significant illness/disease you may have.

BIRTHDATE:(Month)_____ (Day)_____ (Year Not Needed)

Dates of Student Clinical Rotation:

School attending: _____