

**Student Information and Acknowledgement Form**

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| Type of Student: |  |
| Start Date of Clinical Experience: |  |
| End Date of Clinical Experience: |  |

**Student Information:**

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| Student Full Name (MI): |  |
| Phone Number: |  |
| Email Address: |  |
| Home Address: |  |
| Date of Birth: |  |
| Last 4 Digits of Social Security #: |  |

**School Program Contact Information:**

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| --- | --- |
| Name of School: |  |
| Name of Program Coordinator: |  |
| Coordinator Phone Number: |  |
| Coordinator Email Address: |  |

**Hospital Information:**

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| --- | --- |
| Department: |  |
| Preceptor: |  |

*I have reviewed and signed the Confidentiality and Data Security Agreement (HIPPA). I have reviewed The Christ Hospital Code of Conduct, and the Environment of Care (EOC)/Safety Information. I agree to abide by all applicable Christ Hospital Health Network policies. I have been fully vaccinated for COVID-19 and I have received a current seasonal flu vaccine.*

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| **Student Signature:** |  |