

Student Demographic Form

Today's Date

Student Information *(Please Print)*

First Name

Last Name

MI

Last 4 Digits of Soc Sec #

Birthday (Month, Day, Year)

Email Address

Expected Dates of Rotation

DCH Associate Supervising Rotation

School/Organization

Phone Number

Has this individual ever worked at Daviness Community Hospital? Yes/No _____

If Yes, Dates of employment _____

Have you completed a clinical rotation at Daviness Community Hospital in the past? Yes/No

If Yes, Dates of clinical _____

Does your program require access to the Electronic Health Record (EHR)? Yes / No

Have you had previous access to the EHR at Daviness Community Hospital? Yes / No